

Healthcare Transformation Collaboratives Cover Sheet



1. Collaboration Name: Healthcare Transportation: A Ride to Better Health in East St. Louis Metro Area

2. Name of Lead Entity: JewelRide

3. List All Collaboration Members:

JewelRide
Touchette Regional Hospital
SIHF Healthcare
HSHS St Elizabeth's Hospital
St Clair County Health Department
Madison County Health Department
Chestnut Health Systems
Metro-East Pharmacists Association
Faith in Action
National Association for the Advancement of Colored People (NAACP)
Southern Illinois University Edwardsville (SIUE)-Department of Applied Health

4. Proposed Coverage Area: East St. Louis Metro Area (Madison & St. Clair Counties)

5. Area of Focus: Transportation and coordination of trips to medical and non-medical health-related services

6. Total Budget Requested: \$16,004,668

Healthcare Transportation:

A Ride to Better Health in the East St. Louis Metro Area

A proposal from the East St. Louis Metro Area Healthcare Transportation Transformation Partnership

Submitted to the Illinois Department of Healthcare and Family Services

November 30, 2021



St. Clair County
ILLINOIS

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ACRONYMS

ACSC	ambulatory care sensitive condition
AHA	American Hospital Association
CDC	U.S. Centers for Disease Control and Prevention
CHR&R	County Health Rankings and Roadmaps
CHS	Chestnut Health System
CHW	community health worker
CMS	U.S. Centers for Medicare and Medicaid Services
ED	emergency department
EV	electric vehicle
FQHC	Federally Qualified Health Center
HFS	Healthcare and Family Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HSBS	Health Sisters Health System
HTC	Healthcare Transformative Collaboratives
ISHAR	Illinois State Health Assessment Report
MBE	minority business enterprise
MCO	managed care organization
MEPA	Metro-East Pharmacists Association
NAACP	National Association for the Advancement of Colored People
NEMT	non-emergency medical transportation
SDOH	social determinants of health
SIUE	Southern Illinois University Edwardsville
TRH	Touchette Regional Hospital

0. ELIGIBILITY SCREEN

Does your collaboration include multiple external entities?

Yes

Can any of the entities in your collaboration bill Medicaid?

Yes

We plan to use an accounting firm for help in managing direct payments to providers within the collaboration, with the fiscal discipline required to manage small and large payments. The firm will serve in an oversight and advisory role and will monitor and track all payments, invoices, billing requirements, and conduct internal auditing.

YCG Accounting, the firm currently managing all financial and accounting aspects of JewelRide, will help with this role. The firm's expenses are factored into the budget within accounting and legal services. A letter confirming YCG as the accounting firm for JewelRide is included for easy reference. (See Annex 1.)

Also, some members of the collaborating team have extensive knowledge in managing transformational funds. Their experience will be tapped into as part of the process of establishing a strong working collaboration and robust processes.

1. PARTICIPATING ENTITIES

JewelRide, the primary contact for this collaboration, has been serving the community since 2019 and has developed the ***East St. Louis Metro Area Healthcare Transportation Transformation Partnership (the Partnership)***. This multi-sectoral Partnership mobilizes healthcare institutions (universities and hospitals), local organizations, business enterprises, and a faith-based organization to harness their collective power in transforming health outcomes in the East St. Louis Metro Area. The Partnership will facilitate a synergistic approach by leveraging resources to dismantle unfair health, social, and racial patterns while also ensuring health equity for the communities involved. (See Annex 2 for letters of support from partners.)

The Partnership is designed to mitigate the effects of social determinants of health, as well as advance access to quality medical care, healthy foods, pharmacy services, and behavioral health for citizens living in the East St. Louis Metro Area to improve community conditions and health outcomes. The partners selected for the collaboration will foster and facilitate these activities:

- Connecting healthcare delivery systems, including hospitals, outpatient clinics, and treatment centers, with experts on the social determinants of health (SDOH), including non-emergency medical transportation (NEMT) and racial and community action groups and increasing clinicians' and health service providers' ability to address medical and nonmedical issues that affect patient health.
- Enabling East St. Louis Metro Area's health systems to create and strengthen connections with under-resourced and at-risk populations that may not be engaged with the health system.
- Increasing expertise and solutions for SDOH and health-related social needs of patients residing in the East St. Louis Metro Area, building trusting relationships with underserved populations, and pooling knowledge and resources.
- Pooling human and capital resources to enable creation of a cost-effective system that will increase access to health and social services. We believe that strong partnerships will enable this initiative to pool and blend resources and staffing to contribute to making a greater health impact.

The Partnership will be an asset and change driver in achieving health equity in the East St. Louis Metro Area. It will provide people-centered services aimed at improving access to quality care and behavioral health, and reducing healthcare costs for socio-economically vulnerable people through addressing SDOH through such measures as providing transportation and community mobilization services. Also, it will contribute to improving the health of community members by giving them dependable access to medical and non-medical facilities that provide a full range of medical care (e.g., maternal and child health, chronic diseases, family medicine, opioid dependence, dental care, pharmacy services, vaccination services) and specialized behavioral health services, respectively. Table 1 lists and describes key partners in the Transformation project.

Table 1. East St. Louis Metro Area Healthcare Transportation Transformation Partnership

NAME	DESCRIPTION	LOCATION
HOSPITALS		
SIHF Healthcare	A network of safety net outpatient clinics specializing in adult and family medicine, pediatrics, obstetrics and gynecology, behavioral health, and dental care services. SIHF Healthcare is a Federally Qualified Health Center (FQHC). As of November 2021, SIHF runs 22 outpatient clinics and 13 of those 22 are located in Madison and St. Clair Counties.	Madison and St. Clair Counties
Health Sisters Health System (HSBS)-St. Elizabeth's Hospital	A multi-institutional healthcare system that sponsors 15 hospitals in 14 communities across Illinois and Wisconsin, and an integrated physician network.	St. Clair County
Touchette Regional Hospital (TRH)	A safety net community hospital providing medical services to the residents of East St Louis and surrounding communities for over 60 years. This hospital system also provides behavioral health services. The whole group is a safety net healthcare system mainly serving the underserved population in the East St Louis metro area. TRH is an FQHC.	St. Clair County
BEHAVIORAL HEALTH		
Chestnut Health System (CHS)	A state-qualified addiction and mental health treatment health system located, and providing services in, the East St. Louis Metro Area. CHS has more than four decades of experience and expertise in providing comprehensive addiction treatment for adults ages 18 and older. CHS implements research-tested programs that address addiction and mental health to help adults achieve recovery and maintain sobriety.	Madison and St. Clair Counties
COMMUNITY and FAITH-BASED ORGANIZATIONS		
Faith in Action	A community and volunteer-based ecumenical organization working with the community to provide services that support the independence and well-being of seniors age 60 and above in response to the growing population of older Americans in the metro area.	Madison County
National Association for the Advancement of Colored People (NAACP)	A community mobilization and sensitization organization engaging with community members in sharing their lived racial and equity experiences impacting the community.	Madison and St. Clair County Chapters

SUPPORTIVE SERVICES		
Metro-East Pharmacists Association (MEPA)	A network of independently owned pharmacies located in the region who are experts on drug knowledge, medication therapy management, and provision of new prescriptions and prescription refills.	Madison and St. Clair Counties
Southern Illinois University Edwardsville (SIUE), School of Education, Health and Human Behaviour, Department of Applied Health Sciences	A program that focuses on preparing students for a variety of professional and research careers in the diverse areas of health science. Faculty combine their research expertise with outstanding instructional abilities.	Madison and St. Clair Counties
Madison County Health Department	The entity certified by the Illinois Department of Public Health to plan and implement the community health needs of Madison County residents.	Madison County
St. Clair County Health Department	The entity certified by the Illinois Department of Public Health to plan and implement the community health needs of St. Clair County residents.	St. Clair County
NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)		
JewelRide	A certified minority business enterprise (MBE) under the Illinois Department of Central Management Service's Business Enterprise Program. JewelRide provides NEMT for people to access health services at hospitals, treatment centers, and drug stores/pharmacies in the East St. Louis Metro Area spanning Madison and St. Clair Counties.	Madison County

2. PROJECT DESCRIPTION

2.1 Brief Description

Suggested official name for the collaboration: Healthcare Transportation: A Ride to Better Health in the East St. Louis Metro Area

This Partnership aims to promote health equity and address health disparities by generating demand for:

1. Follow-up care from a hospital setting to a non-hospital setting after an emergency department visit or hospital discharge.
2. Community-based care in a non-hospital setting for community members with chronic health conditions, mental illness, and substance use disorder.
3. Transportation to non-emergency medical and non-medical health-related services, including pharmacies and full-service grocery stores/food banks.

The Partnership aims to leverage its abilities to coordinate care among health providers in different settings, reach out to community members to increase health awareness about resources available in the community to address their needs, and break the transportation barriers by coordinating trips to medical visits and non-medical health-related services.

2.2 Detailed Description

According to the National Academy of Medicine, access to healthcare is “the timely use of personal health services to achieve the best health outcomes” (Institute of Medicine, 1993). Attaining good access to care requires (1) gaining entry into the healthcare system, (2) getting access to sites of care where patients can receive needed services, and (3) finding providers who meet the needs of individual patients and with whom patients could develop a relationship based on mutual communication and trust to ensure the continuity of care. The 2021 Illinois State Health Assessment Report (ISHAR) identified behavioral health, chronic disease, and maternal health as statewide health priorities. The report states that access to quality care and SDOH should (1) serve as an implementation requirement for addressing health priorities and (2) be viewed as foundational for achieving health improvement in Illinois. The lack of access is driven by resource gaps as well as social, economic, and other social determinants of health barriers that the communities face. In other words, some of the barriers faced by the communities are modifiable problems that sit within the healthcare system and the social fabric of communities (Musick et al., 2021). The Partnership proposes improved access to healthcare and social determinant solutions (such as transportation and improved health literacy) to mitigate drivers of access to care and ultimately contribute to pathways toward improved health outcomes.

According to the U.S. Centers for Disease Control and Prevention (CDC), genetic, biological, and personal behaviors account for just 25% of an individual's well-being. The remaining 75% of factors are attributed to SDOH, such as housing, safe neighborhoods, food insecurity, and access to transportation and healthcare services (CDC, 2021). In 2017, 5.8 million people across the nation delayed medical care because they did not have transportation. The transportation barrier disproportionately affects minority populations, those living below the poverty threshold,

Medicaid recipients, children, the elderly, and people with functional limitations (Wolfe, McDonald, and Holmes, 2020). The lack of transportation and inaccessibility have severe consequences on patients as well as the overall healthcare system. Evidence shows that transportation barriers are associated with lower healthcare utilization and a lack of regular medical care, especially for those with chronic conditions (Wolfe, McDonald, and Holmes, 2020). Also, 55% of late arrivals or missed medical appointments are due to transportation. While 65% of patients felt transportation assistance would improve medication use, 55% of patients failed to fill a prescription after a hospital discharge due to difficulty obtaining transportation, affecting their adherence to recommended care (Syed, 2013). While Syed's study is nearly a decade old, a recent study by Wolfe, McDonald, and Holmes (2020) showed no change in the trend associated with transportation barriers, suggesting this barrier and its consequences are consistent over time.

With the transformation of the healthcare system under Medicaid to a value-based reimbursement model and the focus on ensuring quality of care and improving patient health outcomes, the infrequency of care due to transportation barriers can affect the quality metrics upon which a provider is being paid. Along with the higher healthcare cost due to discontinuity of care or use of emergency departments (EDs) for primary care sensitive visits, missing appointments are a substantial burden on the healthcare system. One study estimates a loss of \$150 billion per year from no-shows and last-minute cancellations, with a range of \$125–200 per missed appointment (R1, 2020, Weber, 2020); around 50% of this cost could be attributed to transportation barriers.

According to the U.S. Centers for Medicare and Medicaid Services (CMS), Medicaid programs spend \$3 billion annually on NEMT to help low-income and disabled individuals get to and from their medical appointments (CMS, 2020). While NEMT has some quality challenges due to limited operating time and customer satisfaction, which would be addressed in this collaboration, some argue this budget is not enough to cover the needs of Medicaid members facing barriers due to transportation (Baciu et al., 2017). An evaluation by the Medicaid program in Florida concluded the state might save \$11.08 for every dollar spent on transportation if one in 100 subsidized rides prevented patients from being hospitalized due to missed or delayed medical appointments (Cronin et al., 2008).

Medicaid claims and encounter data for 2019 and 2020 show that in the East St. Louis Metro Area the rate of ambulatory care sensitive conditions (ACSCs) at the emergency department accounted for 235.3 and 193.2 visits per 1,000 enrollees in 2019 and 2020, respectively, of which, 166.1 and 132.5 visits per 1,000 enrollees were for acute ACSCs, 49 and 42.8 visits per 1,000 enrollees were for chronic conditions, and 20.2 and 18.8 visits per 1,000 enrollees were for avoidable conditions in 2019 and 2020, respectively. Similarly, hospitalizations due to ACSCs were 19.6 and 16.6 admissions per 1,000 enrollees in 2019 and 2020, respectively, of which 13.7 and 11.5 admissions per 1,000 enrollees were for chronic conditions, 5.7 and 4.9 admissions per 1,000 enrollees were for acute conditions, and 0.2 and 0.1 admissions per 1,000 enrollees were for avoidable conditions in 2019 and 2020, respectively. Also, 4% of Medicaid enrollees with mental, behavioral, and neurodevelopmental disorders received care at the ED in 2019 and 2020, and 16% of these patients were admitted for these conditions in 2019 and 15% in 2020 (Healthcare Transformation Collaboratives, 2021).

In the East St. Louis Metro Area, an evaluation conducted in 2020 by the Chicago School of Public Health, the University of Illinois, highlighted the challenges faced by the community in general and three key populations in particular, those with (1) mental health conditions, including bipolar and depressive disorder, (2) substance use disorder, and (3) chronic conditions who use the ED for ACSCs to access primary and specialty care (Musick et al., 2021). The study found that between October 2017 and June 2018:

- Only 12% of Medicaid patients who went to the ED or were hospitalized (i.e., received hospital-level care) for mental disorders received outpatient care within three months before and 15.5% within three months after hospital-level care. This level of care falls far below the national Medicaid benchmark of 56% of discharged patients receiving follow-up care after 30 days of hospitalization for mental illness.
- Only 16.3% of Medicaid patients with substance use disorders received care before hospital-level care, and 29% received subsequent care.
- For those with ACSCs, only 19.6% received outpatient care before the hospital-level care and 29.5% after.

The low rates of outpatient care before and after hospitalization and ED visits were attributed to poor access to outpatient care. The report concluded that improving access to quality outpatient care will be critical to decreasing hospital admission to prevention-sensitive hospitalization and ACSCs. The lack of access to quality non-hospital settings of primary and specialty care for the vulnerable population is driven by resource gaps and by social, economic, and social determinants of health barriers (e.g., access to transportation, lack of access to affordable healthy food) (Musick et al., 2021).

Discussion with the community in the East St. Louis Metro Area demonstrates the cumulative impact of SDOH barriers. In their report, Musick et al. highlighted the importance of **trusted** sources of health information. Such sources would help residents understand the complexity associated with their health insurance coverage, when to initiate care, how to ensure continuity of care for the key populations mentioned above, and how to adhere to recommendations from their health providers. Residents highlighted the need to access resources that could help them lead a healthy lifestyle, especially for healthy eating. Also, residents shared their concerns about the transportation cost to healthcare services and full-service grocery stores. Most importantly, residents emphasized the scarcity of community-based healthcare facilities that accept their insurance and/or provide relation-based patient-centered care, leading some to seek care outside their community or delay care. Furthermore, the community stated the impact of living in resource deserts of food, green space, transportation, and health facilities while unhealthy food options are readily available.

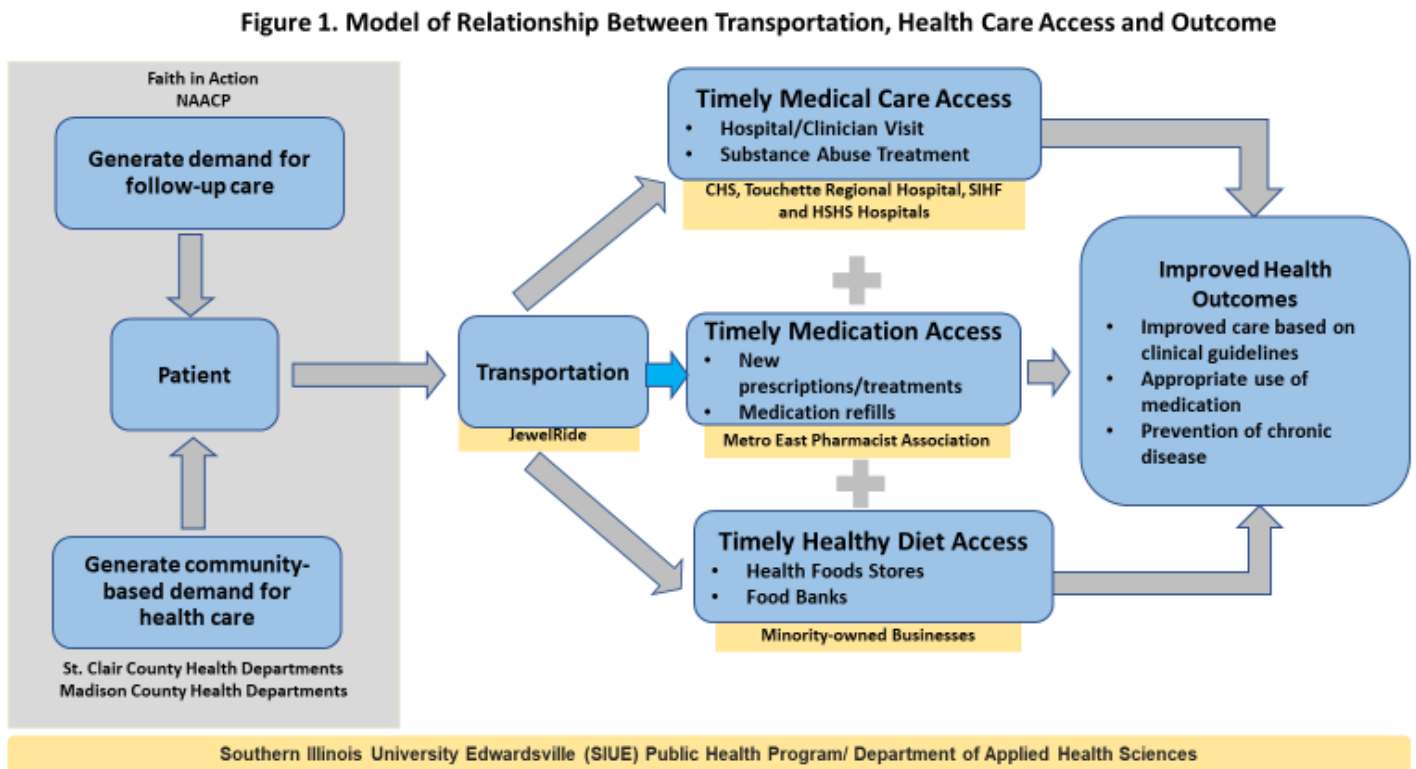
2.3 Major Projects That Shape This Transformation

The Partnership proposes a person-centered framework to manage and coordinate the needs of Medicaid members and vulnerable residents of the East St. Louis Metro Area. This includes those with mental health conditions, substance use disorders, and chronic conditions who use the ED for ACSCs. This **generates demand for follow-up care** after an ED visit or an outpatient visit or a hospital discharge from **TRH, HSHS, and SIHF Healthcare**, where **JewelRide** will coordinate the transportation to **CHS** and **TRH**, other ambulatory care providers such as dialysis facilities, and pharmacies in the patients' catchment areas. (See Annex 3 for letters of support for growing demand.) For dialysis in particular, JewelRide will work closely with Davita Dialysis and Fresenius Kidney Care, the two major dialysis care providers in the East St. Louis Metro area. Also, **St. Clair County** and **Madison County Health Departments** will identify residents with SDOH needs and contact JewelRide to provide them with the needed transportation to healthcare facilities.

To address the low utilization of primary care services and to build trust in the healthcare system, the collaboration will **generate community-based demand for outpatient care** by improving health literacy and addressing the hesitancy to use ambulatory care in a timely manner. Two trusted organizations, **Faith in Action** and **NAACP**, have been working with residents of the East St. Louis Metro Area since 1972. They conduct outreach activities to identify vulnerable populations in their catchment areas, educate and assist them in getting access to health insurance, allocating a provider that accepts their health insurance, booking appointments, and accessing JewelRide services for transportation to and from health providers.

To address the barrier to healthy food options, the St. Clair County and Madison County Health Departments, Faith in Action, and NAACP will coordinate with JewelRide to offer **trips to full-service grocery stores or designated food banks** to improve access to fresh food. During these visits, a food coach/dietician will offer tips on how to examine food labels and determine the quality of food. The three solutions detailed below would provide various solutions for residents, such as opportunities to improve timely access to healthcare, ensure continuity of care, reduce broken and missed appointments due to transportation constraints, and options to adopt a healthier lifestyle, which should improve their health outcomes and reduce the cost of healthcare, as illustrated in Figure 1. Also, CHS, Faith in Action, and NAACP would identify patients who might benefit from smoking cessation services and refer them to JewelRide to help them access this important service.

Figure 1. A holistic person-centered framework to manage and coordinate the needs of vulnerable populations in the East St. Louis Metro Area



As illustrated in Figure 1, the Partnership will leverage resources by creating collaborative efforts among hospitals, substance abuse treatment centers, county departments of health, community organizations, and local enterprises. These parties' goals are to achieve better access to quality care to improve health outcomes and reduce the cost of care by focusing on prevention and timely access to health; ensure continuity of care in the appropriate medical setting; and assist those aspiring to live a healthy lifestyle. This is a transformative and institutional innovation to enable and sustain healthier lives.

The 2021 Transformation Data and Community Needs report suggests that these efforts focused on building and strengthening linkages between the healthcare system, community organizations, and local business enterprises can provide primary and secondary care plus community-based wraparound services. In turn this will help people manage chronic illnesses, mental illnesses, and substance use disorders and reduce SDOH barriers to care and treatment. We believe that improving health outcomes will be achieved if challenges associated with SDOH are addressed as part of the healthcare system. Healthcare system-community-local business enterprise linkages will leverage the treatment expertise of healthcare systems (associated with SIHF Healthcare, HSHS, and TRH, CHS, and the on-the-ground knowledge of community-based organizations and the trust (associated with JewelRide, MEPA, Faith in Action, and NAACP). This will also support a more active approach to healthcare management of the communities. Also, the Transformation project

healthcare system-community-local enterprise linkages is a way to restore trust in the healthcare system among socially vulnerable communities, such as the residents of the East St. Louis Metro Area, and holds the promise of increasing engagement in healthcare over time. If healthcare systems, local business enterprises, and communities can adopt these new ways of engaging with one another, the current healthcare delivery paradigm will shift from siloed and transactional to relationship-based and collaborative for the benefit of the communities.

We provide below detailed, specific solutions that shape this Transformation project and relate directly to health equity:

Goal 1: Generate demand for follow-up care in non-hospital settings after an ED visit or hospital discharge. During the needs assessment, most residents of the East St. Louis Metro Area who were hospitalized did not receive services at a non-hospital setting before or after their hospitalization, and most identified transportation as a barrier to accessing outpatient healthcare services (Musick et al., 2021). The Partnership will generate demand for follow-up care by enhancing the care coordination functionality at the ED departments at HSHS, SIHF, and TRH, for members identified by St. Clair County and Madison County Health Departments and offering transportation to those who need it.

Currently, staff at the ED department of partnership hospitals screen patients for the severity of their condition before providing care. Patients can wait for hours to be seen. While the current care process at the ED is not ideal, it offers the opportunity to connect with and screen patients for SDOH using tools recommended by CMS (CMS, 2020).

The Transformation project will staff the emergency department in HSHS and TRH with two care coordinators at HSHS and one care coordinator at TRH to cover four shifts, including the weekends. Ideally each hospital would need four care coordinators for adequate coverage. However, another approach to building sustainability of the Transformation is having some personnel helping with this role coming from each hospital's existing ecosystem of care coordinators who will be housed within each hospital's respective social work department. These care coordinators will be from the catchment area of each hospital and representative of the population served by the hospital. The care coordinators will be stationed at the emergency department and will be equipped with a tablet with access to the internet. The care coordinators will approach the patient using a protocol developed by the Transformation project, especially for this purpose, and explain their role and how they could help the patient access the needed care at a non-hospital setting in a timely manner.

As illustrated in Figure 2, the care coordinators will ask the patients for their consent to access and review their medical record/care plan and share their contact information with the Partnership, including JewelRide, and follow up with them by phone after the ED visit to coordinate their healthcare needs with healthcare providers in an ambulatory setting. The care coordinator will follow these procedures:

- If the patient consents, the care coordinator will start the process by conducting the SDOH assessment.

- If the patient sought care at the ED department for ACSCs, mental illness, or substance abuse, the care coordinator will review the follow-up care plan with the care team and call the patient within 48 hours of his or her ED visit to coordinate follow-up healthcare needs as recommended in the follow-up care plan.
- If the care coordinator identifies a transportation need as part of the SDOH assessment, then she/he will coordinate the patient's non-emergency transportation needs with JewelRide, including transportation for a pharmacy to fill the patient's prescription. The care coordinator will have a list of healthcare providers, either physical paper or an app, such as Aunt Bertha (FindHelp, 2021), to identify health providers in their catchment area who accept different insurance plans, including Medicaid, and providers who offer free care for the uninsured and schedule an appointment for patients on behalf at the CHS (behavioral health and substance abuse treatment provider).
- When patients are admitted to the hospital due to ACSCs, mental illness, or substance use disorder, the care coordinator will contact JewelRide to coordinate the patient's need for a trip to the outpatient facility and the pharmacy to fill his/her prescription.
- During the flu season (October–May) the care coordinator will also help identify patients needing a flu shot and will refer them to a MEPA area pharmacy as well as arrange transportation through JewelRide.
- After the patient's discharge from the ED and before contacting the patient, the care coordinator will consult with the care team assigned to the patient and review their discharge plan. If it includes the need to follow up with a provider at a non-hospital setting, then the care coordinator will start the process of scheduling the follow-up appointment and the transportation service when needed. For those admitted due to ACSCs, mental conditions, and substance use disorders, the care coordinator will follow up with the patient after discharge and will work with the patient and his or her family to ensure their adherence to the discharge plan, including scheduling a follow-up visit with a primary or a specialist within seven to 30 days of discharge and when needed will share their contact with JewelRide to coordinate the transportation to and from the healthcare provider and to the pharmacy if needed.

During patients' first contact with JewelRide, a staff member will provide them with options on how to contact JewelRide and schedule non-emergency medical transportation services (e.g., phone, email, or website) and will inform them of other services, such as the trip to a full-service grocery store with a food coach, if they fit the eligibility criteria for this service. By year two, a fully functional app will be in place facilitating a seamless user-friendly approach to obtain information, such as appointment reminders and transportation booking capabilities. This will complement human intervention where necessary but we envision it contributing to the sustainability of the Transformation, enabling automation of some processes.

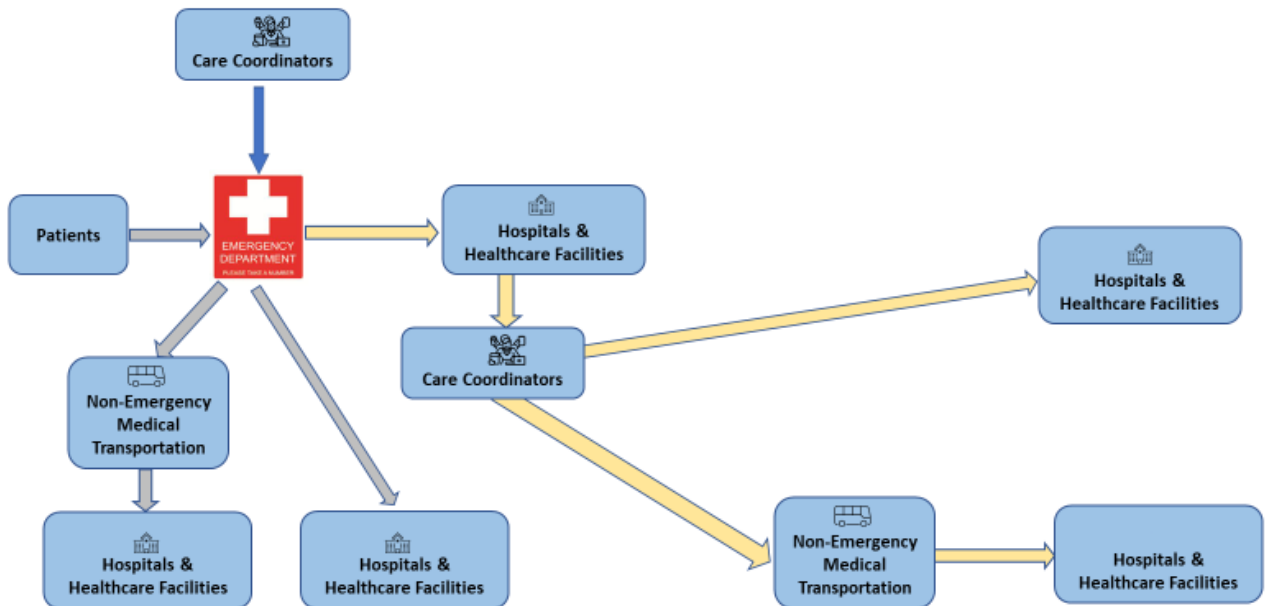
If the patient used services at any of the Partnership's facilities (e.g., CHS), then based on the SDOH needs assessment, a person from the scheduling department will arrange transportation to the next appointment directly with JewelRide. For those with chronic conditions who can benefit from modifying their lifestyle, the Partnership will arrange visits to a nutritionist and refer them to JewelRide to benefit from the health coach and trip to the full-service grocery store services.

By generating demand for follow-up care, we expect the Medicaid patients to use the appropriate level of care for their conditions by helping them identify providers who accept their insurance, help them schedule an appointment with that provider, arrange for transportation to that medical visit, and provide them with counseling and access to nutritious food, especially for those with chronic conditions. As a result, we expect (1) an increase in the percentage of Medicaid members who are screened for SDOH needs, (2) an increase in the percentage of Medicaid patients who used outpatient services after an ED visit or a hospital discharge, (3) an improvement in patient health outcomes (see the next paragraph for details), (4) a reduction in the ED visits and hospital admission to prevention-sensitive conditions and ACSCs, and (5) reduction in the cost of care.

Table 2.1. Expected Health Outcomes Associated With This Goal

Indicator	Current	Goal
Percent of mental illness hospitalizations in the consortium hospitals with a follow-up visit within seven days	15%	35%
Percent of substance use disorder hospitalizations in the consortium hospitals with a follow-up visit within seven days	29%	50%
Unmet specialty referrals for patients who used the consortium hospitals' emergency department	50% (35,561)	10%
Excess emergency department use due to ACSCs	35% (9,370 of 27,832)	20% of visits

Figure 2. Follow-up Care Demand Generation Proposed Under Solution 1



Goal 2: Generate community-based demand for healthcare. Addressing SDOH is an underlying tenet of health improvement work within the state, counties, and communities. The Partnership aims to address several challenges associated with SDOH. Acknowledging the impact of low utilization of outpatient and specialized services on the health outcome and well-being of the region's residents and the challenges faced by the community due to low health literacy, lack of access to transportation, and affordable healthy food (Musick et al., 2021), the Partnership will leverage the trusted relationship between community health workers (CHWs) (associated with Faith in Action and NAACP) and the community to (1) educate the community on various health issues, including mental health and healthy eating, through bi-weekly newsletters and social media posts and seminars, (2) share opportunities such as the food coach and trips to full-service grocery stores or a farmers market organized by JewelRide if they meet certain criteria, and (3) schedule in-person or virtual visits to people in their catchment area known to be struggling with chronic health conditions, mental illness, and substance use disorders.

The Partnership will develop guidelines and policies on approaching the vulnerable community members and working with them to address the roots of their hesitancy to seek care. This will be done through (1) intensive outreach activities for vulnerable populations including the homeless, veterans, people living with disabilities, and the elderly, (2) targeted messaging addressing issues such as healthy eating, smoking, mental health, and substance use disorder, and (3) education campaigns at church, barbershops, and common gathering venues. If the community member decided to seek more information, the CHW would schedule a one-on-one meeting with that member to assess needs. If the community member decided to seek care based on their discussion with the CHW, then the CHW, equipped with a tablet, will screen the member for SDOH needs using the CMS tool and ask for their consent to share their contact information with the project consortium, including a care coordinator at a designated consortium health center to organize that member's care and JewelRide to coordinate the drive to and from the health provider facility.

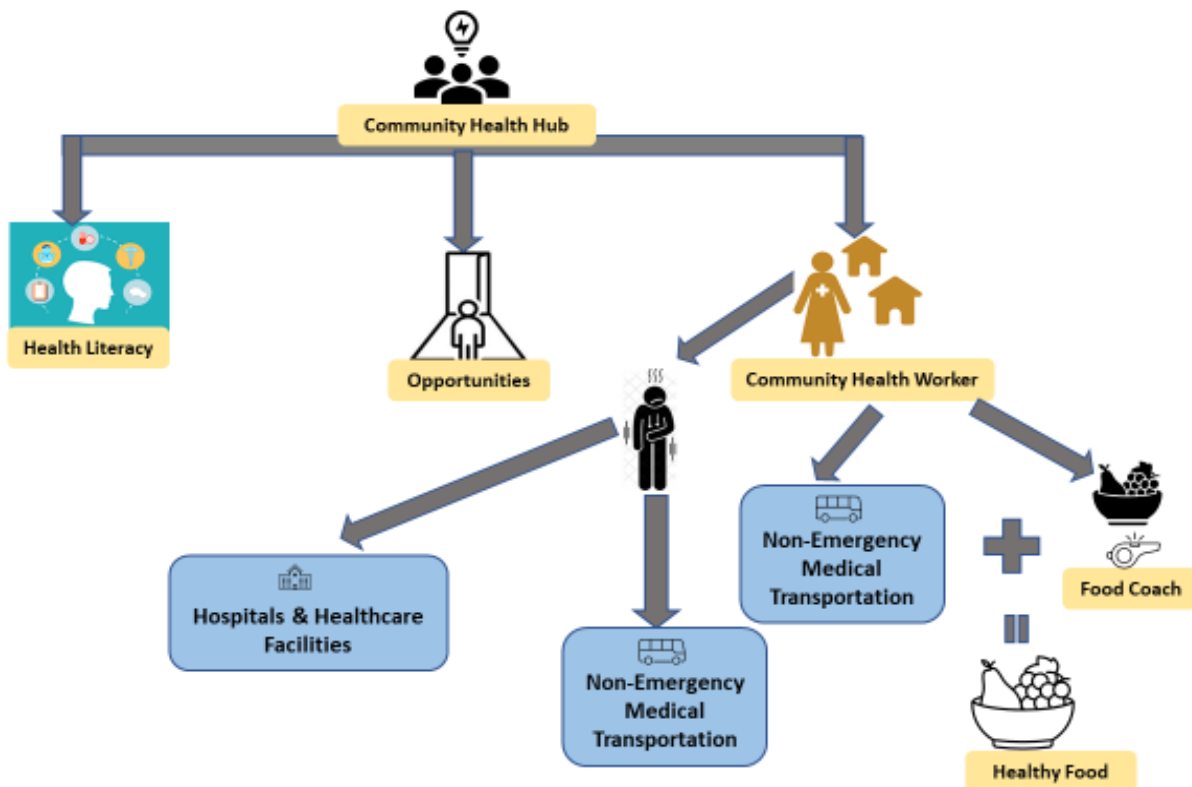
Finally, since nutrition is an important part of a healthy lifestyle, to address the barrier to a full-service grocery store that offers fresh food, the Faith in Action and NAACP will coordinate with JewelRide trips to full-service grocery stores twice a week to improve access to fresh food. During these visits, a food coach will offer tips on how to examine food labels and determine the quality of food, and after consultation with a nutritionist, provide advice on what to buy (Figure 3).

By generating community demand for healthcare, we expect members in need of care to receive the help they need in getting public health insurance if they are eligible, getting assistance in navigating the complex health system and finding a primary care provider, scheduling and keeping their health appointment by addressing the transportation barrier, adhering to the health provider advice by improving their diet and staying physically active, and getting help quitting smoking if desired. Table 2.2 shows the measures for this solution.

Table 2.2 Community-based Demand for Healthcare Indicators and Metrics

OUTCOME	INDICATORS	DATA SOURCE
Community demand to create health equity	<ul style="list-style-type: none"> Number of health educational messages developed by the project consortium 	Institutional data
	<ul style="list-style-type: none"> Number of people reached by the CHWs 	
	<ul style="list-style-type: none"> Number of trips to the full-service grocery store 	Institutional data
	<ul style="list-style-type: none"> Number of people who used the food coach's services 	Institutional data
	<ul style="list-style-type: none"> Member satisfaction and overall health rating 	
	<ul style="list-style-type: none"> Number of people touched who initiated care for their chronic condition, mental illness, and substance use disorder in a non-hospital setting 	Member survey
	<ul style="list-style-type: none"> Number of people who used JewelRide services to address the transportation barrier 	Member survey and JewelRide data
	<ul style="list-style-type: none"> Percent of people touched reporting eating nutritious foods within the past two days (e.g., a serving of a green vegetable) 	Member survey

Figure 3. Community Demand Generation for Care at Non-hospital Setting and Health Literacy, and Access to Opportunity to Empower Patients to Lead Healthy Lifestyles, Solution 2



Goal 3: Generate demand for transportation to non-emergency medical visits and non-medical health-related services including full-services grocery stores. Getting transportation to the healthcare service provider is an obstacle faced by millions of Americans. An estimated 5.8 million people annually don't obtain needed medical care in the U.S. due to transportation issues (American Hospital Association [AHA], 2017, Health Research & Educational Trust, 2017), such as access to vehicles, distance, travel time, and affordability. Transportation issues impact patient access to care by missing or last-minute rescheduling of a medical appointment, delayed care, and missed or delayed medication use, leading to poorer management of chronic illness and poorer health outcomes (Syed, 2013). Mass transit systems are generally available in metro areas but they fall short to fulfil time-bound medical transportation needs for reasons such as limited operating hours and rigid routes and timetables they have to follow, which do not necessarily offer convenience to people needing medical attention. NEMT requires a door-to-door service offered by a well-trained driver who can assist patients with special medical and mobility needs, such as wheelchairs. Furthermore, it requires tailor-made approaches for successful execution.

Moreover, transportation is an obstacle to accessing healthy food, especially for those with chronic conditions like diabetes and hypertension. The Transformation Data and Community Needs Report (Musick et al., 2021) identified lack of resources, i.e., living in resource deserts, with limited transportation infrastructure or insufficient transportation options as community-defined barriers to staying, arranging, and getting to care (Musick et al., 2021; Syed, 2013). This barrier could be solved by providing non-emergency transportation, especially for residents residing in areas with lower social vulnerability, which Madison and St. Clair Counties fall under (AHA, 2017). Several provider-based initiatives demonstrated how addressing the transportation barriers improves access to healthcare (AHA, 2017).

The evaluation by the Chicago School of Public Health describes the basis of residence hesitancy to accessing care in a timely manner. When people decide to seek care, they make an implicit cost-benefit analysis, trading off time, money, and trouble against the value they expect to gain from care. The lack of transportation barriers voiced by community residents tips the balance toward the costs of seeking care and away from the value of getting healthcare.

"If you don't have your own transportation and you're trying to get on the bus [with groceries], there is only so much you can carry. Or, if you have someone take you, you have to pay them and sometimes, they don't want to wait for you so you feel rushed and you don't have time to get what you need."

- Centreville resident (East St. Louis Metro Area) female, 46–55 years old

Source: Musick et al., 2021, p. 46

"If you look at the social determinants of health as well, addressing those would affect all the other things on the list. As we're talking about access to primary care, that can have a lot to do with transportation for people in cities but also often time in rural areas of the state; people can't get to where the care is, due to transportation, where the clinics are located, poverty, etc. Access to good nutrition can also be hard if you don't have access to transportation or are in poverty-stricken areas."

Source: ISHAR, 2021, p. 31

To address this issue, the Partnership will work together to identify members with transportation barriers and develop eligibility criteria for members to opt to use an innovative service that

educates and assists them in how to adopt a healthy lifestyle, starting with consuming nutritious food to mitigate their chronic health condition.

In addressing transportation barriers, the Partnership will develop a procedure guideline on how to securely share patients' information among them and will invite a cybersecurity expert to suggest appropriate software to be used by the partners to facilitate care coordination and to develop data-sharing security procedures to protect patient private information in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) rules (U.S. Department of Health and Human Services, 2020).

When JewelRide receives a transportation request from the care coordinators at TRH, SIHF, HSHS, or CHS and the CHWs at Faith in Action and NAACP, a staff member at JewelRide will work with the care coordinator and CHW to assess the unique needs of that patient and schedule a round trip to and from the healthcare provider. A staff member at JewelRide will call the patient three days before the appointment, and the day of the appointment to confirm the timing of the pick-up and drop-off and the address of the patient and the provider. JewelRide will have policies in place to guide staff in how to communicate with patients, especially the elderly, those hard of hearing, and patients with immune-compromised conditions, to ensure the communication is clear and the client's need is well documented.

Using the confirmation calls, a staff member will ask if the patient has special needs to determine the best transportation option to provide, such as a vehicle that accommodates a wheelchair, and confirm availability (see Figure 4). To make it a seamless experience when people book their rides and in general go through the experience of waiting for the vehicle picking them up before or after an appointment, JewelRide will develop an app accessible to drivers and customers alike to manage rides in real time. When the app is fully functional, people will be able to place an order for a ride and track where their vehicle will be in real time without the need of a phone call as is the current situation. We envision a scenario in which a person can press a button that says, "I am ready to be picked up," and that message will be passed on to drivers using appropriate geolocation. The nearest driver can respond and, in the process, cut wait times once a person is done with a medical appointment and ready to go home. This will be an innovative approach to manage generated demand.

JewelRide currently works with institutional transportation brokers whose role is to organize healthcare transportation for Medicaid-eligible people on behalf of health plans and managed care organizations (MCOs), including but not limited to Blue Cross Blue Shield, Molina Healthcare, Meridian Health, Aetna Better Health, Essence of Missouri, Humana of Illinois, and Wellcare Illinois Medicaid. Under the current model, these health plans obtain Medicaid funding from the Illinois Department of Healthcare and Family Services to cover healthcare services for eligible members. Transportation to obtain medical care as well as pharmacy services is one area covered by these funds. The health plans are not necessarily mobility experts and therefore to manage the transportation component, they contract institutional brokers to handle it. These institutional brokers manage the technology and scheduling capabilities required to find transportation for possibly thousands of people each day across the entire state of Illinois. The brokers do not provide the actual transportation. Instead, they contract healthcare transportation providers to carry out

the actual rides. JewelRide is one of those healthcare transportation companies currently contracted to provide this critical piece of the value chain.

Three institutional brokers that JewelRide is working with are Modivcare (modivcare.com), MTM (mtm-inc.net), and First Transit (firsttransit.com). As of November 2021, JewelRide covers about 100 trips (50 people each having one round trip from home to the healthcare facility) daily on behalf of these three brokers. JewelRide is always under pressure from these brokers to increase capacity by way of having additional HIPAA-compliant vehicles and drivers because the demand for services currently outweighs available transportation providers in the East St. Louis Metro Area. JewelRide will work with these three brokers to accommodate more patients once the capacity increases. A key area we will address using collaborative funding under this proposal is acquiring 25 vehicles and adding a corresponding 25 drivers to dramatically increase our capacity. Working hand in hand with brokers, including proactively updating them when our capacity grows, will be a key feature in generating and fulfilling the demand for transportation to access medical and pharmacy services in the East St. Louis Metro Area.

This collaboration will also provide sustainability during and beyond the duration of the project because equipment such as vehicles will still be there and available for use to fulfill healthcare transportation requests coming through these brokers, which they pay for whenever we provide services. Revenue generated when covering rides coming through institutional brokers will also be a large part of funds that will help with sustaining operations and in the process building a sustainable model. We project that our need for transformative funds will decrease with each subsequent year as we cover more and more rides for institutional brokers with a direct correlation for added revenue.

Also, the Partnership will develop an innovative approach to address accessibility to healthy food. An assessment of community needs at East St. Louis Metro Area demonstrated how environmental barriers and obstacles associated with living in a resource desert are affecting their ability to access food and to break the cycle of unhealthy diet due to the presence of unhealthy food options in the community (Kauth et al., 2021). The Partnership will address these obstacles under Solutions 2 and 3. Through Solution 2, staff from Faith in Action and NAACP will conduct outreach activities to identify residents in their catchment area who might benefit from a change in their dietary habits. Also connecting these members with the needed medical resources, CHWs will refer those members to JewelRide, which will organize trips to a full-service grocery store with the company of a food coach. The coach would advise those members on how to read the food labeling and help them to choose a nutritious and healthy diet that is appropriate to improving their chronic health condition.

JewelRide will enhance its capacity to meet the expected demand for its transportation services by:

- Improving the technical infrastructure by adapting an automated dispatch system and a fully dedicated app that is user-friendly and easily accessed by customers/patients to book services.
- Expanding its operational hours to serve clients 12 hours six days a week.

- Developing and enforcing safety, harassment, and quality control procedures for staff and drivers to ensure customer satisfaction. In addition to a standard background check, all drivers will be trained in First Aid, defensive driving, cardiopulmonary resuscitation, and handling of wheelchair patients (Medicare safety training).

Also, the Partnership will hire food coaches to facilitate and manage the full-service grocery store services. It will develop guidelines and policies to cover eligibility for these services, as well as how to communicate the health information and how to provide these services using a holistic approach. The coach will coordinate these trips with members of the Partnership (mainly CHS, Faith in Action, and NAACP), arrange for the needed transportation based on the number of clients and their unique needs, and develop a coaching plan for each client based on the client's health conditions and needs, to ensure compliance with the health providers' recommendations and best nutrition practices.

We would like to cite two initiatives that the Partnership will embark on to embrace what has become known as the "innovation economy." Of the 25 vehicles purchased through this Transformation project, five will be electric vehicles (EVs). The EVs are powered by renewable electricity and are a centerpiece of efforts to decarbonize transportation. EVs are energy efficient, reduce emissions, and require lower maintenance. They emit fewer greenhouse gases and air pollutants than petrol or diesel cars, which contributes to improving air quality in towns and cities. The State of Illinois aims to put one million electric vehicles on the road by 2030 as part of the Climate and Equitable Jobs Act (September 2021). Illinois's new climate legislation makes available a \$4,000 rebate per resident as a way of incentivizing residents to purchase electric vehicles starting July 1, 2022. Clearly, the future of automobiles is electric.

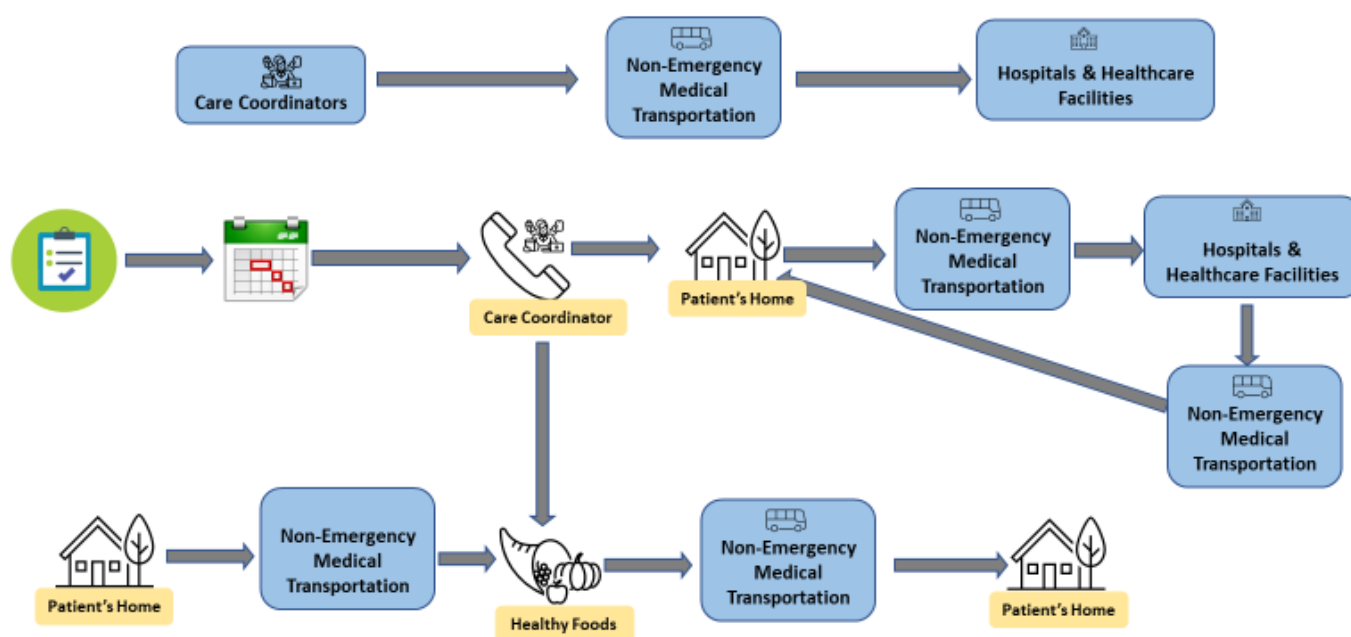
Our Transformation project will take a pioneering role in establishing some key lessons on EVs being used for NEMT and social change. As of November 2021, we are not aware of a medical transportation fleet comprising EVs in the State of Illinois. Using EVs and gas-powered vehicles simultaneously in our transformational approach will allow real-life comparison of factors such as cost, efficiency, time savings and behavioral change. For example, through our academic and research partner, SIUE, Department of Applied Health Sciences, this Transformation project will compare annual maintenance cost of EVs to regular gas-powered vehicles. Using EVs in this project will be not only be transformative but also forward looking with the opportunity to set a useful baseline, which could provide several lessons that will be shared with the Illinois Department of Healthcare and Family Services (HFS) as well as other relevant units like the department of transportation.

Furthermore, our project will work with local authorities and interested entities to explore viable ways of building an accessible charging infrastructure for EVs. The availability of this infrastructure could be a key driver in people adopting EVs for everyday use. The availability of EVs for use at the community level could help with providing real-life exposure (including riding in them), which could assist in creating a culture of adopting EVs to match with moving toward an "electric economy" championed by the State of Illinois.

The second initiative that the Partnership will implement is transforming vehicles to be "learning hubs." Relevant and timely easy-to-read brochures and pamphlets will be made available to all

riders while they are on their way to a medical appointment or drugstore or grocery store to get healthy food options. As an example, if one of the collaborating partners were to run a free prostate cancer screening event, that information would be made available in each vehicle so that the vehicle becomes an information dissemination outlet for critical health and wellness information. Such information would be made available through print and electronic media. Electronically, it would be accessible through an app that we envision would be functional by year 2. People would use the app to book their rides and follow in real time. The app could be designed in such a way that such specific educational information pops up on their phone only when a person is in transit to allow for reading on the way to or from an appointment.

Figure 4. Addressing Patients' Transportation Barriers to Providers in Non-hospital Settings and Challenge of Living in a Resource Desert and its Impact on Nutrition: Solution 3



By addressing the transportation barriers to medical and non-medical health-related services, we will provide members of the community in the East St. Louis Metro Area, especially those with chronic medical conditions, mental illness, and substance use disorders, an opportunity to take steps to use the medical services needed to control and prevent the deterioration of their health. Also, we expect that providing non-medical health-related services to members, especially those with chronic health conditions, would encourage a change in their lifestyle and nutrition, leading to improved health outcomes. Table 2.3 summarizes the expected change and how the change would be measured.

Table 2.3 Demand for Transportation to Medical Visits and Grocery Stores, Indicators, and Metrics

OUTCOME	INDICATORS	DATA SOURCE
Demand for NEMT	• Number of people receiving transportation services to health providers	Institutional data
	• Rate of services met to booked services	Institutional data
	• Client satisfaction with the food coach	Client satisfaction survey
	• Client satisfaction with the transportation services	Client satisfaction survey
	• Number of unique individuals who received services from the food coach	Institutional data

Implementing this proposal could pose several challenges. Below we discuss these challenges and how the Partnership will address them.

1. **Patients' trust in the healthcare system:** The Partnership will seek to employ care coordinators and CHWs from the East St. Louis Metro Area who are familiar with the community and the challenges faced by members in these communities, and who have experience in referring patients to community services or connecting patients to health insurance plans using health connector. The project consortium will invest in training the care coordinators and CHWs on how to initiate the discussion with patients and build trust using respectful and patient-centered approaches and will develop guidelines to ensure the privacy of patients and the information they share.
2. **Patients' adherence to care:** Several factors would influence the patient's adherence to care and most are outside the scope of this project. However, the Partnership will aim to address several barriers stated by community members during the evaluation conducted by the Chicago School of Public Health, the University of Illinois in 2020. The Partnership will (1) assist uninsured patients to get access to health insurance and (2) link patients to providers who accept their insurance or are willing to treat uninsured patients. The care coordinator and the CHW will coordinate care with the appropriate provider, coordinate NEMT when needed, and link patient with community resources needed to address other SDOH barriers. JewelRide will address the transportation barriers by assisting patients in getting their prescription drugs from the pharmacy. Pharmacies within the MEPA system will help with filling prescriptions as well as providing medication therapy management to help with patients' adherence to care. NEMT will be provided that is sensitive and patient-centered to health providers. Access to healthy food options will be provided with a food coach to improve awareness of how to read food labels and select healthy food options.
3. **Data security:** We anticipate that sensitive personal data would be shared among the consortium partners. including patient's name and contact information, address, insurance details, and the provider type they are seeking. The Partnership will use a secured electronic platform such as [Box.com](#) to share information and schedule appointments. A data security expert will oversee the data-sharing agreement and a policy on what, when, and with whom

the data will be shared will be strictly implemented by the data security departments associated with the Partnership.

4. **Overuse and inappropriate use of NEMT services:** To mitigate this challenge, the team will use two strategies. The first strategy would be to identify individuals with a high number of transportation services and review if the reason for their visits is legitimate, and the second strategy will employ a more formal auditing process, where a random sample of transportation rides will be reviewed and evaluated to understand the reason for excess use.
5. **Lack of appropriately converted medical transportation vehicles accommodating wide wheelchairs:** Certain patients may have relatively large scooters and wheelchairs that do not fit in normal size wheelchair accessible vehicles. A typical example would be a bariatric wheelchair or heavy-duty extra-wide wheelchair or extra-weight wheelchair. Of the 25 vehicles that JewelRide will purchase, 20 will be specially converted wheelchair-accessible vans with hydraulic lift systems and a wide ramp that can accommodate all sizes of wheelchairs, including the heaviest ones on the market that are sometimes more suitable for morbidly obese patients. In this way, healthcare transportation will be provided to all people with such a need regardless of wheelchair size or weight.

3. GOVERNANCE STRUCTURE

Collaboration in Governance and Execution Work

The partners will work together and execute the work by adopting a collaborative governance mechanism with structures, processes, rules, and traditions through which decision-making power determines how the work will be executed, and how accountabilities are manifested and actualized across the different Transformation solutions. The Partnership governance structures act as conduits, amplifiers, arbiters, and stewards for allocating and using public resources to create health equity in the East St. Louis Metro Area.

To create project efficiencies and effectiveness, along with pragmatic business conditions that in turn will contribute to improved health outcomes within the region, the work of the Transformation will be supported by establishing a multi-stakeholder representative and balanced governance operating model structure for each individual transformation solution. The variation of the transformation components and solutions does not equate to having a simple governance structure. The governance and accountability structure and mechanism constitute a Regional Advisory Board and three associate Transformation solution advisory boards. The associated advisory boards will facilitate strengthening the Partnership's community and service delivery credibility. The governance model will enable the Partnership to govern, execute, and manage the proposed work, enhancing the Partnership's ability to exercise proper oversight and be a significant driver of partnership effectiveness and cost-efficient performance.

The Regional Advisory Board will facilitate connections, community communications, data sharing, and goal setting, which will assist the Partnership in achieving better health outcomes for our transformation area. This input would allow us to help guide the content in common factors to include in data-sharing agreements and reports.

The Regional Advisory Body and its associate advisor bodies will engender practices of good governance: accountability, transparency, legitimacy, disclosure, participation, decision-making, grievance management, and performance reporting. Credible and effective representative governance structures will enable the Partnership to forge consensus between its stakeholders, which include community voices (associated with Faith in Action, NAACP) as well as state, local business enterprises, and hospital voices. The health departments of Madison and St. Clair Counties will be active and equal partners in all the advisory bodies established within this Transformation.

Partnership performance will depend on how well we make decisions. This in turn will depend on our governance and accountability structures, processes, and norms. A challenge in setting up a governance and accountability of this Partnership is the need to shape relationships between organizations with highly diverse philosophies, rules, and practices of governing their own governance and accountabilities.

The Healthcare Service Delivery Advisory Board will include each of the multiple partners who participate in the transformation solutions toward improved access for healthcare (SIHF, HSHS, and TRH), and mental and substance abuse (CHA) services, including solving for social determinants of health. A contractual agreement will be required to execute a partnership and describe the terms

of participating in our transformation. The governance structure will include data sharing, coordination with CHWs and care coordinators, monthly/quarterly performance reports, biannual analysis of the strengths and challenges of partnership, along with guidance for improvement, optional shared records, and necessary business associate agreements.

The Community Health Hub (CHH) Advisory Board will be a collaborative effort among health, racial, minority, social, and faith-based organizations to formulate the integration, referrals, and assistance to patients and residents in the East St. Louis Metro Area, both to medical and non-medical services. The CHH Advisory Board will represent the bottom-up approach (through community engagement) whereby community-level buy-in will be encouraged and this will enable the Partnership to feed learning and innovation into its work. Each partner and collaborator will be required to execute a contract stipulating the participation rights and responsibilities for being a participant in our CHH Advisory Board. These requirements will guide the responsibilities for adhering to patient care metrics, reporting, and pathways that are coordinated through the CHW Advisory Board (see below).

A CHW Advisory Board consisting of patients and stakeholders will be formed to govern the CHW program. This board will have input on the training, CHW, and care coordinator staffing structure, targeted populations, targeted health and service agencies (including non-medical emergency transportation, health foods, substance abuse), and community outreach activities. Partners in the Transformation project will be required to execute data-sharing and partnership agreements that require monthly and quarterly reporting on their agreed-to metrics that are linked back to our community engagement transformation solutions.

Partners' Authority and Responsibility in Transformation Project Achieving Outcomes

Each partner's technical authority, resources, and responsibility will be leveraged within each governance structure to collectively contribute to improving the health outcome and health equity in our community. This will facilitate providing the communities with a continuum of dependable access to non-medical and medical facilities and services that provide a full range of health (e.g., maternal and child health; chronic diseases) and specialized behavioral health services (substance abuse, mental health), including mitigating for identified SDOH.

Partners' responsibilities toward achieving the health outcomes are outlined below:



JewelRide, a certified MBE, serves as the Partnership lead focusing on facilitating partnership cohesiveness and chairing the Regional Advisory Body. JewelRide's role in improving health equity and access to quality healthcare mainly involves providing NEMT services for clients to (1) get to and from medical appointments to improve access to quality healthcare; (2) improve patients' access to pharmaceutical services for pick-up or home delivery of prescription medications; and (3) improve access to healthy food. Also, its responsibilities include ensuring that the Regional Advisory Board and other associated governance structures will:

i. Create partnership norms

Creation of partnership norms is foundational to establishing our collaborative partnership and good governance. The Partnership believes that successful Transformation is managed by people who recognize the importance and benefit of cultivating healthy working relationships. Given that this Partnership brings together organizations with diverse experiences and organizational maturity, different organizational structures and systems, as well as provides different social and health services, it will be essential for the Transformation project to establish parameters and guidelines on how partners will work together. Partnership norms for our collaborative will be a set of shared values that act as guidelines on how Partnership members will behave and interact with one another overall and within each governance structure.

ii. Design structures for open and honest communication

Open and honest communication will be built by creating norms and structures for facilitated discussion. Our Partnership will broadly and within the governance structures use consistent communication norms in every interaction, and in progress and problem-solving meetings across each transformation activity. We will engage in open dialogue with parameters and include healthy conflict. We will adopt several methods for creating open, honest communication. These might include:

- Build proficiency in the Partnership leaders to develop understanding of at least one proven model of communication and commit to facilitating the model.
- Provide executive/leadership coaching for all leaders within the Regional Advisory Board and associated governance structures to explore values and understand different perspectives.

iii. Craft collaborative work plans

Develop overall transformation and solution-based work plans (including milestones, metrics to track performance against each solution) that outline the structure of work for each clustered partnership or a specific initiative within the Partnership.

iv. Use technology to manage the Partnership

Partnership norms, communication practices, and collaborative work plans will be supported and strengthened through using technology. Several methods for distributing information will be considered to share information across the Partnership network. Information will be distributed through electronic newsletters, websites, and electronic clearinghouses. Web-based databases will be secured in accordance with the compliance of each organization's information technology access and user requirements. The database will be an effective means for multiple organizations constituting the collaborative to collect and track data, especially when customized to the specific needs of our collaborative.

Other core partners in the Partnership include:



Three hospital systems—Hospital Sisters Health System, SIHF Healthcare, and TRH—will share the responsibility of improving health equity and quality of care as they provide primary healthcare services to the region. TRH also provides behavioral health. These anchor institutions will focus on mitigating the effects of SDOH on health outcomes and also include:

- Increasing workforce with living-wage jobs with benefits among local residents through hiring and deploying three care coordinators per hospital to cover four shifts to the EDs.
- Building advocacy and action capacity among community residents and community-based organizations.



Chestnut Health System, a state-qualified organization that offers outpatient and residential treatment with a focus on treatment for alcohol abuse, abuse of prescribed medications, heroin, or other street drugs. For residential patients, care is supervised 24 hours a day. Residents have access to a psychiatrist, medical services, catered meals, and recreation. Also, these residents have individualized continuing care programs developed for them, which may include outpatient counseling and referrals to community support groups. Both types of patients (i.e., outpatient and residential) will require reliable NEMT to enable patients to regularly attend treatment appointments to continue their growth in recovery. Also, CHS offers other types of treatment such as medically assisted treatment and gender-specific treatment, including family counseling for its patients.



Faith in Action, a volunteer-based ecumenical organization endowed with caring and competent volunteers who are mobilized to address the elderly community's needs and advocate for the use of civic resources—including food, elderly care, and addiction care—to address health equity. Within the Partnership, Faith in Action's authority and responsibilities include:

- Being a key partner in advocating for and developing or providing healthcare services as well as in addressing the social determinants of health.
- Being a pillar of trusted sources of health information to help residents to understand (1) the complexity associated with their health insurance coverage, (2) when to initiate care and how to ensure continuity of care, and (3) how to adhere to recommendations from their health providers.
- Providing support to the community and clients to access tools that could help them lead a healthy lifestyle, especially for healthy eating.
- Hiring and supervising community health workers and food coaches/dietitians



The National Association for the Advancement of Colored People, an organization committed to eliminating place-based and race-based health inequities in Illinois. The organization's mechanism of change includes community organizing emphasizing the role of power or the ability to act in change targeting racial inequality, health systems, and SDOH.

NAACP engages community members in sharing their lived experiences, thus increasing the health systems' awareness of the most critical racial and equity issues impacting individual and community health. Also, its responsibilities within the Partnership will include:

- Developing grassroots leadership
- Fostering democratic, accountable, sustainable, community-driven organizations, whose participants are exercising democracy with each other.
- Hiring and supervising community mobilizers advocating and encouraging racial equality in the transformation activities and accessing the healthcare system.

Both Faith in Action and NAACP will engage with communities in socially and economically vulnerable areas to eliminate silos and create connections by reweaving community networks, fostering community engagement, and lifting residents' voices and connection to resources afforded by the State of Illinois through this Transformation project. Both entities will engage communities in conversations and identify barriers to healthcare, disease prevention, and treatment adherence. Also, both will co-lead the development of guidelines and policies on approaching the vulnerable community members and working with them to address the roots of their hesitancy to seek healthcare.



Metro-East Pharmacists Association, an established network of independently owned pharmacies located in the East St. Louis Metro Area and surrounding communities whose members provide direct patient care to meet the prescription medication needs of the communities that they serve, when and where they need it. The pharmacists will bridge the gap for demand by:

- Providing educational consultations on medication and accessibility to improve adherence to prescribed medications through medication therapy management.
- Liaising with NEMT support to assist in the pick-up and home delivery of new and continuing medical prescription for increased patient access to medications by taking away the barriers of transportation and proximity to a pharmacy.
- Providing important emergency medication refills, renewals/extensions of prescriptions
- Participating in outreach events in the communities, churches, workplaces, shopping malls, etc. to educate patients and the community about medications.
- Continuing to provide flu shots and any other shots accessible at community-based pharmacies, e.g., COVID-19 vaccines. Eligible patients use NEMT to access such services, which impacts health outcomes and possibly increases business for pharmacy owners.



SIUE Public Health Program/Department of Applied Health Sciences, an anchor institution responsible for mobilizing knowledge, conducting overall project monitoring, implementing research, and serving as an independent evaluator for the Transformation project. This institution will partner with the hospital systems, substance abuse treatment center, community agencies and organizations, and health departments of Madison and

St. Clair Counties for data collection and analysis. It will facilitate the development and adoption of transdisciplinary research approaches needed to produce evidence for informing work on health equity, SDOH, health outcome, racial equity, and the knowledge base that the difference governance structures can draw on to design solutions to reduce health inequities. Also, the institution will adopt innovations in using and sharing data to bring partners together across the SDOH to highlight connections, create a common language, and monitor progress across various sectors. The university will collaborate with the Community Health Hub Advisory Board to ensure that it:

- Provides community health needs assessment data to enable the Transformation to pursue health equity issues through a more coordinated approach within the diverse stakeholder group committed to advancing health equity.
- Measures and identifies barriers of social inclusion and meaningful participation.



St. Clair County
ILLINOIS

St. Clair County and Madison County Health Departments. Public health agencies throughout the U.S. are focusing their organizational resources on addressing health equity (e.g., the theme of the 2016 National Association of County and City Health Officials' [NACCHO's] annual meeting, "Cultivating a Culture of Health Equity," and the 2016 Association of State and Territorial Health Officials President's Challenge, "Advancing Health Equity and Achieving Optimal Health for All").

The health departments of St. Clair and Madison Counties are no different. These two counties lead opportunities for building and providing resources to improve the performance and impact of health outcomes work in their respective jurisdictions and this Transformation project. These agencies also run clinics targeted at preventive services and other initiatives supporting community health. Also, these health departments:

- Play supportive roles in executing transformation solutions to address health equity,
- Provide the Partnership and use population based health data to identify health priorities and health disparities
- Inform and help mobilize the community and stakeholders to address health priorities in this Transformation project
- Evaluate and monitor the health effects of the proposed social determinants of health and health outcomes of the Transformation project

These departments act as the natural conveners of health equity stakeholders across the different solutions and governance structures, including healthcare systems, community organizations, etc. Also, they are partners with or conveners of faith-based organizations (e.g., Faith in Action), minority businesses enterprises (e.g., JewelRide), and other governmental agencies.

Both departments will be engaged in the early phases of work planning through contributing data, epidemiologic expertise, partnerships, and community engagement capacity in addition to commitments to achieving health equity. Also, these departments support each transformation

governance structure in establishing appropriate baseline metrics to track progress toward meeting project goals, including participation, and to monitor the impact of the program on health outcomes. The departments will be strategic partners with the SIUE Public Health Program/Department of Applied Health Sciences on research and evaluation to demonstrate program effectiveness.

Effective Financial Management System and Safeguards

The Partnership recognizes the importance of establishing and operationalizing a solid and effective financial management system that engenders policies on accountability, ensures transparency, and enables participatory decision-making and performance reporting across the different transformation solutions and governance structures. The financial system(s) will adhere to all financial and administrative requirements of the Healthcare Transformative Collaboratives (HTC) and the State of Illinois, including the participating partners. (See Annex 1 for accounting firm confirmation.)

All payment of transformation funds will be tracked centrally with JewelRide serving as the overall Partnership fiduciary and grants manager, and financial reports will be required of participating entities to ensure funds continue to be spent as appropriate and legally for the purposes of this Transformation. TRH, HSHS, and SIHF Healthcare as well as CHS have extensive fiscal departments that have managed external and grants relationships and reporting from the host of healthcare and social service entities. These members of the different advisory boards will assist in the structure needed to ensure specific oversight to the Transformation funds and the projects across the different transformation solutions.

The financial management systems across the different governance structures and partners will provide the foundation for three pillars of sound fiscal governance:

- **Strategizing**, or identifying what needs to happen financially for the Partnership to achieve its short- and long-term goals and effectively contribute to improving health equity and health outcomes in the East St. Louis Metro Area. The different advisory boards will need insights into current performance for scenario planning, for example.
- **Decision-making**, or helping the Partnership including the advisory boards to decide the best way to execute on action plans by providing up-to-date financial reports and data on relevant KPIs and metrics.
- **Controlling**, or ensuring each partner is contributing to the vision and operating within budget and in alignment with goals and aspirations of the Partnership and HTC.

Each governance structure and the Partnership, overall, will ensure that the following financial management systems, policies, and procedures are available to facilitate them to use the funds appropriately and transparently (see Table 3.1).

Table 3.1. Financial Management System and Safeguards for Fiduciary Accountability

Written Financial Policies	Expenses Are Documented	Efficient Accounting System	Transparent Budget Controls
Partners operate within a written set of financial policies and procedures, mostly guided by each organization's own policies	All staff are familiar with documentation requirements for grants	Distinguish grant-versus non-grant-related expenditures	Properly approved budget for each partnership, which will serve a financial blueprint to help the Partnership meet its goals and objectives
Partnership staff within the operative and governance structures are familiar with policies and procedures	All expenses have supporting documentation that directly relates to expenses funded under the Transformation grant	Identify costs by program year and budget category	The Partnership, at the governance and individual partner levels, will periodically review budget to actual expenses
Partnership financial policies and procedures are up to-date	Partners have proper record retention policies	Differentiate between direct and indirect costs (administrative costs)	The Partnership, at the governance and individual partner levels, will ensure budget changes are properly approved
Financial policies and procedures incorporate grant provisions	Documentation supports expenditure requirements: reasonableness, necessity, allocability, allowability, and adherence to grant guidelines	Record in-kind contributions as both revenues and expenses	The Partnership, at the governance and individual partner levels, will review movements between line items and verify if they are within provisions and/or guidelines
		Allow governance structures to obtain financial reports, summary or detailed	Budget changes should be approved by the JewelRide and governance structures if they are changes in scope, objectives or goals of the program; additional sub-grants or contracts; or line-item changes greater than the established percentage of the grant
		Correlating accounting information and documents to financial reports submitted to the granting agency	

Reporting is another important function of the financial management and oversight structure. Again, through internal policies and procedures, it will be about what financial reports the Partnership will produce, what technical issues they will cover, who will receive the reports, who will produce the reports, what format the reports will take, and how often the Partnership team or governance structures should submit the reports. The **financial reporting system** will enable:

- All financial reports to be supported by the accounting system and that they should match information in the general ledger.
- Final financial status reports to be due within 90 days after the end of the grant and this must be cumulative over the life of the grant.

- Financial records must be retained for at least three years from the date of the submission of the state Financial Status Report.

The financial management system will have internal controls and safeguards to ensure that:

- Follow-ups are done to confirm that financial practices and expectations are met.
- Financial duties are properly segregated.
- The accounting system tracks grant and partners other funds separately.
- The accounting system is used to create financial reports.
- Proper safeguards over assets exist.

3. RACIAL EQUITY

Black residents, especially those in East St. Louis City, and Medicaid members and residents who are eligible for Medicaid but not enrolled in the program, would benefit from this Transformation project. The Partnership will operate in areas known for their health disparities, vulnerability, and scarcity of resources. For example, more than 90% of East St. Louis City residents are Black with a per capita income of \$16,987. Similarly, in Cahokia City, 58% of the population is Black, 1% is Hispanic, and the per capita income is \$18,045, the poverty prevalence is 30.3%, and 43.7% of the population is on Medicaid. By contrast, the community of Highland, Illinois (only 33 minutes from East St. Louis and 37 minutes from Cahokia) is dramatically different. The prevalence of poverty is 9.6% (less than a third of that in Cahokia). The population is 2% Black, some 30 times lower, and 4% Hispanic, and only 11.9% are on Medicaid (about a quarter of the rate in Cahokia). These illustrative geographies show that these communities with high shares of the Black population have substantial poverty and substantial rates of Medicaid insurance. Hispanic minorities are consistently small shares of the population in both these communities.

As the geographical example above indicates, the community with a substantial Black population was poorest; the community with the highest white share was the least disadvantaged. Given the geographic-related economic and social disparities that are equally associated with race, this Transformation project provides solutions to promoting health equity and addressing health disparities with a bias toward distressed communities of East St. Louis Metro Area whose residents are mainly Blacks. In this regard, the goals of the Transformation project are aimed at (1) generating demand among residents in distressed communities for follow-up care in a non-hospital setting after an emergency department visit or hospital discharge; (2) generating community-based demand for care within these communities in a non-hospital setting for members with chronic health conditions, mental illness, and substance use disorder; and (3) generating demand for transportation to medical and access to healthy food full-service grocery stores.

As the service areas (St. Clair and Madison Counties) have higher shares of Blacks than Illinois and the U.S. as a whole, the expected improvement in access to care in these counties will particularly benefit that community and help to maximize equitable impacts. While the share of Hispanics in these counties (4.3% and 3.4%, respectively) is lower than that in the U.S. as a whole (18.5%), the project will still address equity by helping to facilitate access to care among the poorest members of that ethnic group.

Stakeholders from TRH and NAACP were especially helpful to the team led by JewelRide in designing this Transformation project. (See Annex 5 for NAACP letter of support.) The NAACP was established in 1909 to advance justice for African Americans, and it still represents the Black community. The NAACP branch based in Centerville, Illinois, only five miles from the center of East St. Louis, especially serves and represents the perspective of the Black community. NAACP's mechanism of change includes community organizing, emphasizing the role of power or the ability to act in change targeting racial inequality, health systems, and SDOH. It engages community members in sharing their lived experiences, thus increasing the health systems' awareness of the most critical racial and equity issues impacting individual and community health engagement. Dialysis facilities (Davita Dialysis and Fresenius Kidney Care) in Madison and St. Clair Counties were also included. Dialysis is a critical, often lifelong procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly. Poor and vulnerable communities, most of which are made up of minority

populations, tend to be disproportionately affected in accessing dialysis services. A key area that this project is providing is increased access to dialysis care for people living in the East St. Louis Metro area. An effort was made to have Davita Dialysis as an official collaborating partner but that could not be achieved, as its legal department required more time to have such a decision approved through Davita's corporate structure. However, Davita Dialysis indicated that the organization will link patients requiring transportation assistance with the Transformation project's work once implementation has started.

Although we are not aware of causal analyses specifically in Monroe or St Clair counties, national analyses of uptake of COVID vaccination are informative. Based on data from 43 states, the Kellogg Family Foundation reported that 55% of the white population, 53% of the Hispanic population, but only 48% of the Black population had received at least one dose. One reason for low uptake generally, but especially among Blacks, is distrust of the healthcare system, with origins dating back to the infamous Tuskegee syphilis study in which Black persons with the disease were left untreated even as penicillin came into use.

The lack of health resources and services in this region has been driven by white flight and medical services following this population. The segregated and medical services flight has included loss of the region's major employers, and over two-thirds of the residents in East St. Louis fled for the suburbs within the State of Illinois. This has had consequences for the communities in the East St. Louis Metro Area with the area falling into state and federal debt as crime and corruption began to rise. Consequently, the debt resulted in the loss of significant medical services culminating in the closure of two of the community's hospitals (Christian Welfare in the 1980s and Kenneth Hall Regional Hospital in 2016), leaving East St. Louis City—one of the most poorly health served and most dangerous cities in Illinois—without an emergency room. The current trend in the area has been to see socio-economic and health resources being channeled away from these communities. For example, one hospital in Belleville underwent a relocation that moved it further away from the East St. Louis Metro Area and another Belleville Hospital opened a new more modern facility on the east side of the community further from East St. Louis City. Both facilities are conveniently located near more economically viable populations, leaving the East St. Louis Metro Area with dated facilities not matching those of their neighbors with better health outcomes. Concomitantly, community health systems have limited access or have denied access completely to those on Medicaid and those without health insurance. The region also has very limited services, such as specialist care and acute emergency care.

An evaluation conducted by the Chicago School of Public Health, the University of Illinois in 2020 highlighted the challenges faced by the community in general and three key populations in particular, those with (1) mental health conditions, including bipolar and depressive disorder, (2) substance use disorder, and (3) chronic conditions who use the ED for ACSCs to access primary and specialty care (Musick et al., 2021). The study found that between October 2017 and June 2018, (1) only 12% of Medicaid patients who went to the ED or were hospitalized (i.e., received hospital-level care) for mental disorders received outpatient care within three months before and 15.5% within three months after the hospital-level care. This level of care falls far below the national Medicaid benchmark of 56% of discharges receiving follow-up care after 30 days of hospitalization for mental illness, (2) only 16.3% of Medicaid patients with substance use disorder received care before hospital-level care, and 29% received subsequent care, and (3) of those with ACSCs only 19.6% received outpatient care

before hospital-level care and 29.5% after (Musick et al., 2021). The low rates of outpatient care before and after hospitalization and ED visits were attributed to poor access to outpatient care. The report concluded that improving access to quality outpatient care will be critical to decreasing hospital admissions to prevention-sensitive hospitalization and ACSCs in the East St. Louis Metro Area. The lack of access to quality non-hospital-setting primary and specialty care for the vulnerable population in the East St. Louis Metro Area is driven by resource gaps and by social, economic, and social determinants of health barriers, such as access to transportation and lack of access to affordable healthy food (Musick et al., 2021).

Stigma against those seeking care for mental illness or substance use disorder is high. To mitigate this, the Partnership will train CHWs and care coordinators, including JewelRide staff, to appropriately communicate with patients and their families and to comply with HIPAA regulations. For example, JewelRide staff transporting patients to medical appointments will be trained to refrain from asking about the nature of the appointment or condition for which the transport is being given, or any other aspect of the rider's medical condition.

According to the CDC, genetic, biological, and personal behaviors account for just 25% of an individual's well-being. The remaining 75% are attributed to factors associated with SDOH, such as housing, safe neighborhoods, food insecurity, and access to transportation and healthcare services (CDC, 2021). The Partnership aimed to address some of these SDOH, non-emergency medical transportation and access to healthy food. However, other SDOH factors, outside the scope of this proposal, might help reduce inequality in health outcomes.

The Partnership agrees that sustainability is important and included many steps within the project design to ensure success in that dimension. For example, the budget shows increasing amounts of revenue from other sources, so that the project services become less reliant on collaboration resources over time. As illustrated in the governance section, there are numerous committees to ensure two-way dialogue—receiving stakeholder participation and ensuring reporting back to stakeholders and the public.

In developing success indicators, the Partnership carefully considered the data that are already being collected to manage the project. It wanted to avoid asking patients questions about their racial or ethnic identity that might be offensive. Accordingly, our main indicator will be a breakdown of the origin of rides by the community served. The Partnership will monitor the distribution of rides by the pick-up location. It will link these locations with the census to determine the percentage of minorities. Success will consist in having a large share of pick-ups from predominantly minority communities.

4. COMMUNITY INPUT

The Partnership sees community input from a two-dimensional perspective. The first dimension consists of input gathered from selected key informants during the development of this Transformation project proposal. The second dimension pertains to active community engagement—stakeholder participation in further ideation and development of certain components and activities during project and Transformation activity implementation. Both of these dimensions are addressed below. Community input is key to the success of implementing the Transformation project, which aims to impact individual and community health outcomes and health equity. The Transformation project is deliberate at addressing community engagement in an effort to secure stronger ownership, maximize and sustain project impact, and strengthen overall community resilience.

The service area for the Transformation project is the East St. Louis Metro Area, which encompasses St. Clair and Madison Counties. The focus of much of our transformation solutions is the hardest-impacted communities of East St. Louis, Cahokia Heights (inclusive of Centreville, Cahokia, and Alorton), Washington Park, Venice, Brooklyn, Fairmont City, Alton, Granite City, and Madison, Illinois. These transformation-focused communities share the highest proportion and concentration of the African American population, whose health has been impacted the most by very low incomes and economic instability, and unfavorable social conditions. East St. Louis Metro Area has a high Social Vulnerability Index (SVI) score due to poverty, lack of access to public transportation, and crowded housing, which puts it at high risk of health problems and makes it susceptible to health inequality (Musick et al., 2021). Madison County ranked 70th on health outcomes, such as premature mortality, poor physical health, and poor mental health while St. Clair was ranked 94th out of the 102 Illinois counties. Both counties were ranked in the 4th quantile, demonstrating that communities living in these geographies were experiencing worse health outcomes. Data sources for community information on health outcomes and SDOH include the Transformation Data and Community Needs Report: East St. Louis Metro Area, published by the University of Illinois Chicago, U.S. census data, health data from the CDC, and data from local health departments.

In developing this proposal, selected key community stakeholders were engaged through key informant discussions to solicit community inputs to the solutions of this Transformation project. For example, among community hospitals within the East St. Louis Metro Area, we talked with the president of TRH. He noted that a major issue facing the region was that African American and other minority populations faced poor health outcomes and that SDOH were very low in the communities where these populations resided. TRH suggested that one solution to improving health equity, healthcare access and subsequently improving health outcomes, was to double down on increasing healthcare NEMT in the distressed communities. TRH noted transportation access challenges facing patients travelling to distant places after being discharged from hospitals, such as deep into central and southern Illinois. TRH is a safety net hospital; it caters to the needs of people coming outside their normal service areas. TRH recommended that this challenge be addressed by acquiring vehicles that will cover such long distances.

From a behavioral and substance abuse treatment solution perspective, we had a discussion with the site manager of the Southern Illinois Treatment Center (opioid addiction treatment methadone clinic). The informant cited that a major challenge this sector faces is disrupted continuity of care due to limited transportation to healthcare facilities. For example, most of the methadone patients get

their doses under the directly observed treatments scheme, implying that they need to be at the clinic every day to get their medication under observation and also get counselling. We wanted Southern Illinois Treatment Center to be a collaborating partner but could not get approval in time for this proposal submission. However, our work will address transportation constraints affecting continuity of care for the community of patients needing to access behavioral and substance abuse treatment. Through our CHW program, individuals desiring to attend smoking cessation activities will be provided with transportation to facilities offering such services.

Furthermore, we sought to understand the needs of dialysis patients who need to access outpatient treatment about three times per week. A representative from dialysis indicated that dialysis is a lifelong treatment that patients can't afford to miss. She cited concerns for wheelchair-bound patients who have constrained access to healthcare facilities due to limited transportation providers with wheelchair-accessible vans. Under this Transformation project, at least 20 wheelchair-accessible vans will be purchased to address this challenge.

The NAACP provided input on its efforts to address social justice as well as racial issues at the community level. This input informed our decision to (1) design a Community Health Hub Advisory Board into the governance model and (2) have a CHW program. Our Transformation activities will include deploying three CHWs to each county to extensively engage with the community to link patients to behavioral, specialist care, preventive care, and health food services through health education, increasing health literacy of patients and linking them to NEMT services when needed. We also engaged Faith in Action with the goal of learning more about its community-based transport referral program for seniors. We hope that through Faith in Action's active partnership in this collaboration the organization could build sustainability pillars within its volunteer-based program. Three CHWs will be engaged under Faith in Action and more importantly, the organization is one of the conveyors of the Community Health Hub Advisory Board.

Another key informant, the Edwardsville Deputy Fire Chief, expressed the need to increase NEMT in the regions less-resourced/distressed communities. He said in his more than 30 years of service in the fire department, he has been seeing an increase in the number of 911 calls not necessarily because of a critical emergency need but because the callers didn't have transportation to get to a medical facility on their own. He remarked that a solution to this problem would be improved access to cheaper or free transportation.

To gain a better understanding of the role of healthcare transportation in providing pharmacy services to patients, we spoke with the pharmacy manager and owner of Shields Pharmacy, an independent and minority-owned pharmacy in Alton, Illinois. He made the following points: (1) finding companies that can reliably offer prescription delivery services is a huge challenge; (2) delivering prescriptions, especially to elderly patients and other patients without easy access to transportation, is an essential extended responsibility for pharmacists; (3) expanding healthcare transportation could create positive healthcare outcomes for the community and could also be good for his business and pharmacy businesses in the region. The pharmacy manager is a member of MEPA, a collaborating partner in this Partnership and Transformation project.

Also, we gathered community inputs from the owner of a not-for-profit food bank called Soup and Share (<https://www.soupnshare.org/>) in Granite City, located within the East St. Louis Metro Area.

One interesting finding was that the foodbank sometimes lacks clients who come to pick up free food. Through the provision of NEMT and through our CHW program, we envision improved access to healthy food options for patients in need of such services.

A people-centered approach to project management that incorporates community involvement is needed and is being adopted by the Transformation project through its Community Health Hub governance structure. We recognize that effective community engagement is an actionable strategy that will continuously align the project and community interests and will create sustained mutual benefits. Inclusive community engagement practices will have the capacity to create a shared vision for the metro area's health future; and when successful, the health outcomes in this area will reflect the community's values and likely increase its support. The Transformation activities will ensure that community engagement is built on the principles of meaningful participation and social inclusion. To achieve this, the Transformation project will embrace values of openness, fairness, truthfulness, diversity, responsiveness, deliberativeness, and competence.

The Hub (see Governance section), with Faith in Action (a faith organization) and NAACP (racial and social justice organization) designated as the conveners, will develop an extensive project plan for community engagement, including soliciting input from local elected officials. The Hub will create a community engagement and social inclusion strategy that will detail the (1) purpose of engagement and inclusion [to inform, to solicit feedback, etc.], (2) types of stakeholders who each will require different communication and outreach strategies, (3) resources and scale of engagement-sharing available resources and funding being allocated to outreach and engagement activities in the project, (4) types of approaches and adopting appropriate tactics on whether the intent is to inform, engage, or empower communities, and (5) implementation and modification of the Transformation project community engagement strategy. In sum, the principles of effective community engagement to be adopted in this work are premised on the IAP2's spectrum of public participation. This model advocates increasing levels of shared decision-making authority, with progression from merely informing citizens to the ultimate state of empowerment. Deliberative communication and engagement secure full participation and ownership by community members.

During implementation and management of the project, the Hub will begin taking public comments either through public hearings or through email on a draft framework for gathering community feedback on project implementation. The public meetings will facilitate meaningful civic participation, collaboration, and dialogue between members of a community to build a shared vision. Community engagement is not a one-size-fits-all approach. A range of activities will be needed to reach stakeholders, engage the people most critical to the project, and motivate those people to participate. The board will be updating the project website as it receives public comment and works closely with other members of the Partnership to develop mitigation activities and will provide updates by email for people who sign up and post those updates on the website. The board will hold a series of public meetings throughout the metro area. Those who wish to submit public comments will do so by email or community events to be organized by the board. At these meetings, the board will present brief information about the progress of the project. Residents can get first-hand information on how the project is working toward improving their health and can consider reimagining and redirecting some of the adopted approaches through offering their comments.

Throughout community engagement processes, the Hub will convene meetings with local, state, county, and federal elected officials on the community engagement components of our transformation. Also, community engagement will include beneficiaries, local leaders, community groups, non-profits, business owners, and city or town commissions that could influence the project and its implementation. Community and public meetings or any community event will reflect the demographics and socio-economic status of beneficiaries and different geographies within the metro area. The community engagement will adopt a social inclusion lens that will ensure that the terms under which individuals and groups take part in the project improve their abilities, opportunities, and dignity in accessing quality health services.

SIUE, Department of Applied Health Sciences will create metrics that will be used to track community participation in the Transformation project lifecycle. They will be used also to document the maturity of participation from being mere informants (providing balanced and objective information in a timely manner) through consultation (the project obtaining feedback on analysis, issues, alternatives, and decisions) and then having the project working with the public to make sure that concerns and aspirations are considered and understood (involvement), driving more importantly toward (1) developing a collaborative and ownership-driven association with community members and (2) empowering the community whereby the Partnership places final decision-making in the hands of the public.

5. DATA SUPPORT

We conducted an environmental analysis, a systematic analysis of internal and external factors and how they affect processes and outcomes, to better understand the factors affecting the health outcomes of East St. Louis Metro Area residents, including those who reside in East St. Louis City, Cahokia Heights, Washington Park, Sauget, Brooklyn, Venice, Madison, Granite City, and Alton. According to the 2019 census data and the CDC SVI, these communities are the most distressed in the State of Illinois, with an average per capita income of \$16,987 in East St. Louis City and \$26,645 in Granite City (U.S. Census American Community Survey, 2019; CDC SVI). Health disparities among the mostly African American residents of this community are evident in the excess use of ED visits for ACSC visits, mental illness, and substance use disorders (Musick et al., 2021).

Table 6.1 shows the ranking on health outcomes and health factors for the East St. Louis Metro Area (Madison and St. Clair Counties) compared to the 102 counties in Illinois. Madison County ranked 70th on health outcomes, such as premature mortality, poor physical health, and poor mental health while St. Clair ranked 94th out of the 102 Illinois counties. Both counties were ranked in the 4th quantile, demonstrating that the communities living in these geographies were experiencing worse health outcomes. Also, Madison (ranked 62nd) and St. Clair (ranked 96th) were ranked in the 4th quantile, indicating that both counties had worse health due to societal factors when compared to other counties in the state.

The Community Health Improvement Plans for the two counties in the East St. Louis Metro Area highlight a concern that most of the leading causes of death and sickness affecting metro area residents can be prevented through access to quality care (through demand creation and access to non-emergency transportation) or improved lifestyle modifications (e.g., access to affordable healthy foods, access to alcohol, tobacco, and other substance use prevention services).

Table 6.1 Ranking of Madison and St. Clair Counties on Health Outcomes and Health Factors

MEASURE	DESCRIPTION	RANKING	
		Madison	St. Clair
HEALTH OUTCOMES		70	94
Length of Life	Premature death	65	89
Quality of Life	Poor or fair health, poor physical health days, poor mental health days, low birthweight	76	97
HEALTH FACTORS		42	94
Health Behaviors	Adult smoking , adult obesity, food environment index , physical inactivity, access to exercise opportunities, excessive drinking , alcohol-impaired driving deaths, sexually transmitted infections, teen births	69	100
Access to Clinical Care	Uninsured rates, primary care physicians, dentists, mental health providers, preventable hospital stays, diabetic monitoring, mammography screenings	30	55
Social and Economic Factors	High school graduation rates, some college attendance, unemployment, children in poverty, income equality, children in single-parent households, social associations, violent crime, injury deaths	43	81
Table Source: Robert Wood Johnson Foundation, University of Wisconsin Population Health Institute, 2019, County Health Rankings. Ranking: 1 st Quantile (Ranks 1–26), 2 nd Quantile (Ranks 27–51), 3 rd Quantile (Ranks 52–76), and 4 th Quantile (Ranks 77–102)			

According to the National Academy of Medicine, access to healthcare is “the timely use of personal health services to achieve the best health outcomes” (Institute of Medicine, 1993). Attaining good access to care requires (1) gaining entry into the healthcare system, (2) getting access to sites of care where patients can receive needed services, and (3) finding providers who meet the needs of individual patients and with whom patients could develop a relationship based on mutual communication and trust to ensure the continuity of care. The 2021 Illinois State Health Assessment Report (ISHAR) identified behavioral health, chronic disease, and maternal health as statewide health priorities. The report states that access to quality care and social determinants of health should (1) serve as an implementation requirement for addressing health priorities and (2) be viewed as foundational for achieving health improvement in Illinois. The lack of access is driven by resource gaps and by social, economic, and other social determinants of health barriers that the communities face. In other words, some of the barriers faced by the communities are modifiable problems that sit within the healthcare system and the social fabric of communities (Musick et al., 2021). The Partnership proposes improved access to healthcare and social determinant solutions (such as transportation and improved health literacy) to mitigate drivers of access to care and ultimately contribute to pathways to improved health outcomes.

According to the CDC, genetic, biological, and personal behaviors account for just 25% of an individual's well-being. The remaining 75% are attributed to factors associated with SDOH such as housing, safe neighborhoods, food insecurity, and access to transportation and healthcare services (CDC, 2021). In 2017, 5.8 million people delayed medical care at the national level because they didn't have transportation. The transportation barrier disproportionately affects minority populations, those living below the poverty threshold, Medicaid recipients, children, the elderly, and people with functional limitations (Wolfe, McDonald, and Holmes, 2020). Lack and inaccessibility of transportation have severe consequences on patients as well as the overall healthcare system. Evidence shows that transportation barriers are associated with lower healthcare utilization and a lack of regular medical care, especially for those with chronic conditions (Wolfe, McDonald, and Holmes, 2020). Also, 55% of late arrivals or missed medical appointments are due to transportation. While 65% of patients felt transportation assistance would improve medication use, 55% of patients failed to fill a prescription after a hospital discharge due to difficulty obtaining transportation to get to a pharmacy, affecting their adherence to recommended care (Syed, 2013). While Syed's study is nearly a decade old, a recent study by Wolfe, McDonald, and Holmes (2020) showed no change in the trend associated with transportation barriers, suggesting this barrier and its consequences are consistent over time.

With the transformation of the healthcare system under Medicaid to a value-based reimbursement model and the focus on quality of care and improving patient health outcomes, the infrequency of care due to transportation barriers can affect the quality metrics on which a provider is being paid. In addition to the higher healthcare cost due to discontinuity of care or use of emergency departments for primary care sensitive visits, missing appointments are a substantial burden on the healthcare system. One estimate suggests a loss of \$150 billion per year from no-show and last-minute cancellation, with a range of \$125–\$200 per missed appointment (R1, 2020; Weber, 2020); around 50% of this cost could be attributed to transportation barriers.

Medicaid programs spend \$3 billion annually on the non-emergency medical transportation program to help low-income and disabled individuals get to and from their medical appointments (CMS, 2020).

While NEMT has some quality challenges due to limited operating time and customer satisfaction, which would be addressed in this collaboration, some argue this budget is not enough to cover the needs of Medicaid members facing barriers due to transportation (Baciu et al., 2017). An evaluation by the Medicaid program in Florida concluded the state might save \$11.08 for every dollar spent on transportation if 1 in 100 subsidized rides prevented patients from being hospitalized due to missed or delayed medical appointments (Cronin et al., 2008).

Medicaid claims and encounter data for 2019 and 2020 show that in East St. Louis Metro Area the rate of ACSCs at the ED accounted for 235.3 and 193.2 visits per 1,000 enrollees in 2019 and 2020, respectively, of which 166.1 and 132.5 visits per 1,000 enrollees were for acute ACSCs, 49 and 42.8 visits per 1,000 enrollees were for chronic conditions, and 20.2 and 18.8 visits per 1,000 enrollees were for avoidable conditions in 2019 and 2020, respectively. Similarly, hospitalization due to ACSCs were 19.6 and 16.6 admissions per 1,000 enrollees in 2019 and 2020, respectively, of which 13.7 and 11.5 admissions per 1,000 enrollees were for chronic conditions, 5.7 and 4.9 admissions per 1,000 enrollees were for acute conditions, and 0.2 and 0.1 admissions per 1,000 enrollees were for avoidable conditions in 2019 and 2020, respectively. Also, 4% of Medicaid enrollees with mental, behavioral, and neurodevelopmental disorders received care at the ED in 2019 and 2020, and 16% of these patients were admitted for these conditions in 2019 and 15% in 2020 (Healthcare Transformation Collaboratives, 2021).

In the East St. Louis Metro Area, an evaluation conducted by the Chicago School of Public Health, the University of Illinois in 2020 highlighted the challenges faced by the community in general and three key populations in particular, those with (1) mental health conditions, including bipolar and depressive disorder, (2) substance use disorder, and (3) chronic conditions who use the ED for ACSCs when accessing primary and specialty care (Musick et al., 2021). The study found that between October 2017 and June 2018:

- Only 12% of Medicaid patients who went to the ED or were hospitalized (i.e., received hospital-level care) for mental disorders received outpatient care within three months before and 15.5% within three months after the hospital-level care. This level of care falls far below the national Medicaid benchmark of 56% of discharges receiving follow-up care after 30 days of hospitalization for mental illness.
- Only 16.3% of Medicaid patients with substance use disorder received care before hospital-level care, and 29% received care after.
- For those with ACSCs, only 19.6% received outpatient care before the hospital-level care and 29.5% after (Musick et al., 2021).

The low rates of outpatient care before and after hospitalization and ED visits were attributed to poor access to outpatient care. The report concluded that improving access to quality outpatient care will be critical to decreasing hospital admission to prevention-sensitive hospitalization and ACSCs in the East St. Louis Metro Area. The lack of access to quality non-hospital setting primary and specialty care for the vulnerable population in the East St. Louis Metro Area is driven by resource gaps and by social, economic, and social determinants of health barriers, such as lack of access to transportation and to affordable healthy food (Musick et al., 2021).

Discussion with the community in the East St. Louis Metro Area demonstrates the cumulative impact of SDOH barriers. In their report, Musick et al. highlighted the importance of **trusted** sources of health information to help residents understand the complexity associated with their health insurance coverage, when to initiate care and how to ensure continuity of care for the key populations mentioned above, and how to adhere to recommendations from their health providers. Residents highlighted the need to access tools that could help them lead a healthy lifestyle, especially for healthy eating. Also, they shared their concerns about the transportation cost to healthcare services and full-service grocery stores. Most importantly, residents highlighted the scarcity of community-based healthcare facilities that accept their insurance or provide relation-based patient-centered care, leading some to seek care outside their community or delay care. Furthermore, the community highlighted the impact of living in a resource desert where options for food, green space, transportation, and health facilities are limited while unhealthy food options are readily available.

This environmental analysis led the project consortium to develop three key goals, to generate demand for:

1. Follow-up care from a hospital setting to a non-hospital setting after an emergency department visit or hospital discharge.
2. Community-based care in a non-hospital setting for community members with chronic health conditions, mental illness, and substance use disorder.
3. Transportation to non-emergency medical and non-medical health-related services, including full-service grocery stores.

These goals would influence the health outcomes as presented in Table 6.2 and are aligned with the Department of Health's Quality Strategy.

Table 6.2. Indicators to be Tracked by the Transformation Project

Indicator	Current	Goal
Percent of mental illness hospitalizations in the consortium hospitals with a follow-up visit within seven days	15%	35%
Percent of substance use disorder hospitalizations in the consortium hospitals with a follow-up visit within seven days	29%	50%
Unmet specialty referrals for patient who used the consortium hospital emergency department	50% (35,561)	10%
Excess emergency department use due to ACSCs	35% (9,370 of 27,832)	20% of visits

6. THEORIES OF CHANGE: HEALTH EQUITY AND OUTCOMES

A severe absence of health equity in the East St. Louis Metro Area has led to a series of poor health outcomes among its communities. The lack of health resources and services in this region has been driven by white flight and medical services following this population. The segregated and medical services flight has included the loss of the region's major employers, and over two-thirds of the residents in East St. Louis fled for the suburbs within the State of Illinois. This has had consequences for the communities in the East St. Louis Metro Area with the area falling into state and federal debt as crime and corruption began to rise. Consequently, the debt resulted in the loss of significant medical services, culminating in the closure of two of the community's hospitals (Christian Welfare in the 1980s and Kenneth Hall Regional Hospital in 2016), leaving East St. Louis City as one of the most poorly health served and most dangerous cities in Illinois, without an emergency room.

The current trend in the area has been to see socio-economic and health resources being channeled away from these communities. For example, one hospital in Belleville underwent a relocation that moved it further away from the region, and another Belleville Hospital opened a new, more modern facility on the east side of the community further from East St. Louis City. Both facilities are conveniently located near more economically viable populations, leaving the region with dated facilities not matching those of their neighbors with better health outcomes. Concomitantly, community health systems have limited access or have denied access completely to those on Medicaid and those without health insurance. The East St. Louis Metro Area also has limited services, such as specialist care and acute emergency care.

Table 7.1 shows health disparity conditions negatively affecting the East St. Louis Metro Area in comparison with state and national figures. This clearly shows extensive disparities in health outcomes with the region performing poorly within the state and compared with the U.S.

Table 7.1. Health Disparities

Disparity	East St. Louis	Illinois	United States
Infant mortality rate per 1,000 births	12.9	6.5	5.7
Diabetes (adults 18+)	17.6%	14.4%	8.5%
Hypertension	46.7%	37.0%	32.2%
Breast cancer screening	51.0%	78.7%	78.3%
Obesity (county health rankings)	37%	30%	30%

Striving to help the metro area attain a higher level of health equity, this Transformation project pledges to work on (1) improving physical access to health services through use of NEMT, (2) mobilizing clients toward accessing health services, including health foods through the use of CHWs who aim to improve the health education and health literacy in the community, (3) providing opportunities for job creation, promoting, and retention practices to ensure diversity and inclusion; and (4) forming stronger partnerships with communities of color to improve health outcomes and

leveraging their united and powerful voice (through the Community Health Hub) to advocate for policy changes that address the root causes of racism and social injustice.

Also, the Partnership directly seeks to improve health equity in the distressed communities of the East St. Louis Metro Area with improved health conditions and outcomes through enhanced patient support by means of improved client access and care provided by three participating hospital systems and substance abuse treatment centers for the underserved populations. For example, the Transformation project will staff the emergency department in HSHS and TRH with care coordinators. TRH is the community hospital arm, while SIHF is a network of outpatient clinics located in Madison County (five outpatient facilities) and St. Clair County (eight outpatient facilities) effectively covering our geographical scope in the Transformation project. TRH also provides behavioral health services, including substance abuse prevention. TRH and SIHF Healthcare are part of a safety net healthcare system serving primarily the underserved population in the East St. Louis Metro Area. Both institutions are FQHCs.

Persistent and long-standing under-investment across economic, social, and healthcare in the East St. Louis Metro Area has created conditions that have contributed and led to multiple health risks and social challenges among the communities in the region. Many of the local business enterprises and racial and social equity organizations struggle to address the full breadth of health-related needs due to the overwhelming economic and social issues affecting the communities in the region. Below is a list of inequities that have been demonstrated to affect communities of color much more than majority white communities. Specific equity issues directly affecting the healthcare delivery system in the community include a lack of:

- Care management services to overcome a lack of health literacy and health education in the community
- Connection to the health-related resources available in the community, such as health foods

Achieving a community with greater health equity requires a comprehensive reimagining of the health and healthcare services provided in both cultural approaches and delivery methods within the St. Louis Metro Area. Care management (associated with TRH, HSHS, and SIHF health systems including CHS), outreach (associated with Faith in Action), more convenient access through provision of non-emergency medical transportation (associated with JewelRide), cultural sensitivity, and community engagement (associated with Faith in Action and NAACP) are all necessary steps that a collaborative partnership for transformation must pursue to contribute to improved health equity and health outcomes. Below are specific activities in this Transformation project that relate directly to health equity:

Connecting the Community to Health through CHWs and Community Health Hub

Working toward achieving the Transformation project goals, the Partnership's Community Health Hub will advance culturally competent care and equity for all HSHS, SIHF, and TRH patients, including patients under the CHS. The Community Health Hub will be the center of this Transformation project's health education, outreach, and social services support space. Also, the Hub, through the recruitment of CHWs (i.e., community members who may not have medical training but are a key resource in helping people navigate the healthcare system, especially for the

specific needs of at-risk populations) and care coordinators, will focus on developing and attracting minority service providers, with the recognition that this contributes to the quality and cultural competency of service delivery and also enhances equity in the care the hospital and treatment system provides to the citizens of the East St. Louis Metro Area.

Also, beyond the hospital and healthcare system walls, listening and responding to the needs of the community (through the Community Health Hub and CHWs), with particular attention to persons who are economically poor or from distressed communities, is part of the Transformation solutions to improving health equity. The Partnership and CHW approach will identify patients with unstable socio-economic circumstances, redirect them to a primary care provider, and assist with social needs, such as NEMT to access healthcare and healthy food resources (i.e., food coach and food banks).

The CHWs will help build individual and community capacity to improve health outcomes by increasing health education and health literacy through a range of activities, such as outreach, community education, informal counseling, social support, and advocacy. The integration of CHWs on clinical care teams (associated with the three Partnership hospitals) is a strategy that can be considered to straddle healthcare system interventions and community-hospital/health facilities links. Our CHWs will work to remove the social barriers to healthcare faced by many low-income African American patients in this area, affect behavioral changes, and prevent unnecessary ED and hospital visits. Our CHWs will (1) be organized into teams targeting specific health outcomes to enable these workers to fully immerse themselves in the most effective ways to support patients suffering from specific diseases; (2) actively engage in local health-related functions for community engagement (through the Community Health Hub) and maintain an operational knowledge of services available in the communities and how they are best accessed; (3) work closely with staff from the new Transformation project and be rooted into the operations across our Partnerships to assist in integration with care teams at the three hospital institutions (including the substance abuse treatment center) and into the community where they can provide health education and outreach; and (4) assist in our healthy food initiatives in the community.

Follow-up Care in Non-hospital Settings After an ED Visit or Hospital Discharge

Findings of a needs assessment on residents of the East St. Louis Metro Area who were hospitalized show that they did not have services at a non-hospital setting before or after their hospitalization, and most identified transportation as a barrier to accessing outpatient healthcare services (Kauth et al., 2021). The Transformation project will generate demand for follow-up care by enhancing the care coordination functionality at the ED at HSHS and TRH.

Currently, staff located in the ED of participating hospitals screen patients for the severity of their condition before providing care, keeping patients waiting for hours to be seen. As the current care process at the ED is not ideal, it offers the opportunity to connect with and screen patients for SDOH using tools recommended by CMS.

The Transformation project will staff the EDs in HSHS and TRH with care coordinators to cover four shifts, including weekends. These care coordinators will be from the community and representative of the population served by the hospitals. The care coordinators will approach the patient using

a protocol either developed by the Transformation project or already existing protocols to help the patient access needed care at a non-hospital setting in a timely manner.

The care coordinators will follow up with patients through phone calls after the ED visit to coordinate their healthcare needs with healthcare providers at an ambulatory setting. If the patient sought care at the ED for ACSCs, mental illness, or substance abuse, then the care coordinators will review the follow-up care plan with the care team and call the patients within 48 hours of their ED visit to coordinate their follow-up healthcare needs as recommended in the follow-up care plan. If the care coordinators identify a transportation need as part of the SDOH assessment, then she/he will coordinate the patient's non-emergency medical transportation needs with JewelRide, including transportation for a pharmacy to fill the patient's prescription or transportation to purchase healthy foods or collect food at the food bank.

For patients who are admitted to the hospital due to ACSCs, mental illness, or substance use disorder, the care coordinators will contact JewelRide to coordinate the patient's need for a trip to the outpatient facility and the pharmacy to fill his/her prescription. After the patient's discharge from the ED and before contacting the patient, the care coordinators will consult with the care team assigned to the patient and review the patient's discharge plan, and if it includes the need to follow up with a provider at a non-hospital setting, then the care coordinators will start the process of scheduling the follow-up appointment and the transportation service when needed. For those admitted due to ACSCs, mental conditions, and substance use disorder, the care coordinators will follow up with the patient after discharge and will work with the patient and his or her family to ensure their adherence to the discharge plan, including scheduling a follow-up visit with a primary or a specialist within 7 to 30 days of discharge. When needed, care coordinators will share their contact with JewelRide to coordinate transportation to and from the healthcare provider and to the pharmacy.

8. THEORIES OF CHANGE: HEALTHCARE ACCESS

Limited access to healthcare is an important equity and social issue in the East St. Louis Metro Area and persists as a significant burden on residents in the distressed communities. The low-income people, as well as racial and ethnic minorities of this region, receive lower-quality care and encounter more obstacles to healthcare access compared to other groups. Our Partnership believes that access to healthcare means having “the timely use of personal health services to achieve the best health outcomes.” Good access to care in this region includes three distinct steps, which this Transformation project aims to accomplish: (1) achieving entry into the healthcare system through, for example, providing NEMT services (see SDOH section), (2) obtaining access to essential healthcare services through deployment of care coordinators, and association with SIHF and TRH, which are offering preventive, primary, and specialist care, and (3) locating providers that can meet patients’ individual needs and with whom they can communicate and build a respectful and trusting relationship through the Community Health Hub and CHW approach [see Governance and Community Input sections]. Access to healthcare is critical for optimal health and wellness; thus, addressing obstacles that occur at each of these steps is important for improving the patient experience and health outcomes.

CHS, SIHF, and TRH are key entities of this Transformation project with the purpose of increasing access to preventive, primary or specialty care in communities. For example, over 50% of primary care referrals from SIHF providers for specialty consults are unmet due to the current lack of providers, denials due to payor source, and providers no longer accepting Medicaid MCOs. These circumstances have led to a severe lack of access to care in the East St. Louis Metro Area that directly impacts the health and well-being of the community. Access, equity, and value are issues that our Partnership aims to solve to ensure that communities of transformation receive the level of services they need and deserve.

Within the East St. Louis Metro Area there is a long-standing grave concern about the trust and respect of the healthcare providers by patients under Medicaid and the uninsured. This lack of trust also interferes with the population’s commitment to their health and belief in healthcare being there for everyone. Currently, limited specialty services are offered in the immediate service area for Medicaid and uninsured patients. To remedy this situation, within the Partnership, SIHF Healthcare, HSHS, and TRH, including SIUE, Department of Applied Health Sciences, will provide specialty care in the community in a more accessible ambulatory care center (associated with the current TRH East St. Louis Metro Area Health Transformation Partnership) and non-emergency medical transportation approach associated with our Transformation project. The Ambulatory Care Center under the TRH East St. Louis Metro Area Health Transformation Partnership would embed this Partnership to address regional unmet needs for Medicaid and uninsured patients through face-to-face visits, e-medicine, peer-to-peer consultations, expanded dental access, and outpatient surgery. Integrating these services within TRH and SIHF will remove physical and financial barriers for individuals on Medicaid and those that are uninsured, thus enabling changes to access and health status and outcomes for the East St. Louis Metro Area community. Furthermore, for those who qualify for Medicaid or health insurance subsidies through the federal health exchange, SIHF will assign patients to one of their current healthcare navigators specializing in health insurance sign-up and how to operate the healthcare marketplace website.

Furthermore, the TRH East St. Louis Metro Area Health Transformation Partnership established an Urgent Care Center in midtown East St. Louis with walk-in access for primary care and acute services. The Center caters to some residents who prefer walk-ins for accessing health services. Studies have shown that low-income individuals have difficulties in scheduling access to health services in advance and getting time off during their regular working hours. The established walk-in center with expanded service hours under the above-mentioned transformation project allows patients to access services when they can, rather than hoping they can navigate barriers on their own and make and complete all medical appointments they need.

Also, our Transformation project will deploy CHWs who will directly address access to care barriers to preventive and primary care. CHWs will serve as a liaison, link, and intermediary between health and social services and the community to improve access to healthcare and cultural competence of service delivery. CHWs will link patients to (1) transportation services supported by the JewelRide that already offers over 20,000 rides per year to the communities seeking medical care, helping to address transportation barriers to care, and (2) a host of supportive services to remove barriers to care through partnerships with other collaborators in the Transformation project. Linking services in this way takes the often long and difficult process of identifying and contacting multiple service providers out of the patient's hands and into the hands of a qualified individual with a wide range of knowledge of what services are available and how to access these services.

9. THEORIES OF CHANGE: SOCIAL DETERMINANTS OF HEALTH

It is estimated that up to 70% of an individual's health outcomes are the result not of the quality of the direct medical care they receive but by every aspect of how and where people live, often referred to as the social determinants of health. The significance of the SDOH means that improving healthcare, through expanding access to health insurance or building new local hospitals, will not create the largest impact. Rather, the community needs to improve social determinants, such as housing, wealth, transportation, education, and neighborhood livability.

Access to these opportunities often looks different based on place of residence, race, or the circumstances into which one was born (2020 County Health Rankings and Roadmaps (CHR&R)). The CDC indicates that the SDOH can be allocated into five general categories: (1) economic stability, (2) education access and quality, (3) healthcare access and quality, (4) neighborhood and built environment, and (5) social and community context. For the people of the East St. Louis Metro Area, negative social situations strongly affect each of these categories. However, in this Transformation project, the SDOH solutions are tailored toward improving economic stability, healthcare access and quality, education access and quality, and social and community context. According to the 2020 CHR&R, Madison (ranked 62nd) and St. Clair (ranked 96th) were ranked in the 4th quartile of social determinants of health, indicating that both counties had worse health factors when compared to other counties in the state. The Community Health Improvement Plans for the two counties in the East St. Louis Metro Area highlight a concern that most of the leading causes of death and sickness affecting its residents can be prevented through access to quality care (through demand creation and access to non-emergency transportation) or improved lifestyle modifications (e.g., access to affordable healthy foods, access to alcohol, tobacco and other substance use prevention services).

The 2021 ISHAR report states that access to quality care and SDOH should (1) serve as an implementation requirement for addressing health priorities and (2) be viewed as foundational for achieving health improvement in Illinois. The lack of access to health is driven by both resource gaps and by social, economic, and other SDOH barriers that the communities face. In other words, some of the barriers faced by the communities are modifiable problems that sit within both the healthcare system and within the social fabric of communities (Kauth et al., 2021). This Transformation project proposes healthcare and social determinant solutions (such as improved NEMT, improved access to health literacy, etc.) to be adopted through this work to mitigate drivers of access to care and ultimately contribute to the communities pathway to improved health status.

Economic Stability

The service area for the Transformation project is the East St. Louis Metro Area that inhabits both St. Clair and Madison Counties. The focus of our transformation solutions is the hardest socio-economic and health-impacted communities of East St. Louis, Cahokia Heights (inclusive of Centreville, Cahokia, and Alorton), Washington Park, Venice, Brooklyn, Fairmont City, Alton, Granite City, and Madison, Illinois. These transformation-focused communities share the highest proportion and concentration of African American residents in the East St. Louis Metro Area whose health has been impacted the most by very low incomes, low economic stability, and social conditions. The East St. Louis Metro Area has a high SVI score due to poverty, low employment

rates, lack of access to transportation, and crowded housing, which put it at high risk of health problems and make it susceptible to health inequality (Kauth et al., 2021).

The Transformation project through the anchor institutions (participating hospitals), minority-owned business enterprises, and community-based organizations can lead or participate in championing and implementing job creation and sustenance solutions in the East St. Louis Metro Area. Creating employment is seen as being of significant value to driving and contributing to the communities' economic stability and mitigating SDOH, which the lack of negatively affects improving access to health, and subsequently improving health outcomes. With respect to building communities economic stability, anchor institutions such as hospitals (HSHS, SIHF, and TRH), minority-owned businesses (JewelRide), and community organizations (Faith in Action, NAACP) have an affinity for the residents of distressed communities and are committed to the community's economic development. These organizations are becoming increasingly important as generators of jobs for disadvantaged communities.

A significant portion of the workforce in minority-owned firms is drawn from low-income neighborhoods in the East St. Louis Metro Area; indeed, some of the most successful minority-owned enterprises are in low-income neighborhoods. The Transformation project will directly increase their economic investment and contribute to economic stability in the local neighborhoods through (1) creating jobs through the anchor institutions, minority business enterprises, e.g., job creation through NEMT improvement, engaging CHWs, and employing waged employees in the three-hospital system; (2) enabling significant local and minority purchasing to increase minority business opportunities; and (3) providing contract opportunities for local small businesses. These job creation approaches are couched in the SDOH framework and are highly consistent with the role of multi-sector collaboration. Also, the SDOH framework shows the importance of shared value as motivating forces for the Partnership to play a strategic role in improving living conditions and quality of life in the East St. Louis Metro Area.

Healthcare Access and Quality

Access to healthcare in the communities within the East St. Louis Metro Area has limitations due to a lack of medical and non-medical services, and having service delivery methods that are often a poor fit for the specific needs of the patients residing in the region. Specialty care is difficult and almost impossible to access in the East Metro Area community, especially for patients who are on Medicaid or are uninsured. The East St. Louis Metro Area is currently experiencing a backup of almost 36,000 unmet specialty care referrals. Furthermore, the region has no integrated urgent care center that can create alternative acute access, resulting in frequent and overutilization of EDs. SIHF and TRH will be providing specialty services and urgent care through another Transformation project being led by TRH.

In the East St. Louis Metro Area, an evaluation conducted by the Chicago School of Public Health, the University of Illinois in 2020 concluded that improving access to quality outpatient care will be critical to decreasing hospital admission to prevention-sensitive hospitalization and ACSCs in the East St. Louis Metro Area. The lack of access to quality non-hospital setting primary and specialty care for the vulnerable population in this region is driven by resource gaps and by social, economic, and social determinants of health barriers, such as access to transportation and lack of access to

affordable healthy food (Musick et al., 2021). The transportation barrier in the region disproportionately affects minority populations, people living below the poverty threshold, Medicaid recipients, children, the elderly, and people with functional limitations. Lack of and inaccessibility to transportation have severe consequences on patients' health outcomes as well as the overall healthcare system. Evidence shows that transportation barriers are associated with lower healthcare utilization and a lack of regular medical care, especially for those with chronic conditions (Wolfe, McDonald, and Holmes, 2020). Late arrivals or missed medical appointments have often been associated with a lack of transportation. The infrequency of care due to transportation barriers can affect the quality metrics upon which a provider is being paid. Also, in some studies, patients felt transportation assistance would improve their medication use, as a large proportion of patients failed to fill a prescription after a hospital discharge due to difficulty obtaining transportation to a pharmacy, affecting their adherence to recommended care (Syed 2013).

Moreover, transportation is an obstacle to accessing healthy food, especially for those with chronic conditions like diabetes and hypertension. The Transformation Data and Community Needs Report (2021) identified that social determinants such as living in resource deserts with limited transportation infrastructure or insufficient transportation options as community-defined barriers to staying, arranging, and getting to care. This pain point can be eased by providing NEMT, especially for communities with lower social vulnerability which Madison and St. Clair Counties fall under. After all, providing transportation services can improve access to care and important medications, which can positively impact long-term care outcomes. When people decide to seek care, they make an implicit cost-benefit analysis, trading off time, money, and trouble against the value they expect to gain from care. The lack of transportation barriers voiced by community residents tips the balance toward the costs of seeking care and away from the value of getting healthcare.

Social and Community Context

People's relationships and interactions with family, friends, co-workers, and community members can have a major impact on their health and well-being. Overall community safety negatively affects relationships between individuals in the community. The social and community context in which people live includes the relationships formed between neighbors and their social and civic connections. Positive relationships and social support, meanwhile, can reduce the impact of these stressors, improving health and well-being.

The Transformation project intends to implement a model that focuses on making changes to the food system to address poor access to healthy food, a SDOH. Healthy food insecurity, the lack of or limited access to such food, is an important SDOH in the East St. Louis Metro Area. Healthy food deserts can be found in the East St. Louis Metro Area, where supermarkets or grocery stores that sell healthy food are scarce, directly contributing to healthy food insecurity. These areas may instead have more convenience stores, which are more likely to sell processed, shelf-stable goods rather than fresh produce. As a result, residents may have to travel to find healthy food, which can be more challenging for those without reliable access to transportation. Many communities in the region have limited access to healthy and affordable foods because of transportation challenges or distances to get to healthy food options. In partnership with several minority business enterprises, the health food system approaches to address healthy food

insecurity may include strategies to improve access and promote increased availability and affordability of nutritious foods. These include:

- Improving access to healthy foods through providing NEMT to grocery stores or food banks that are community-owned and stocking healthy foods.
- Improving access to health by advocating community-based and minority-owned stores to better stock and market healthier products.
- Providing community health education and outreach related to nutrition or food access.

Health Education and Health Literacy Access to Quality Services

Discussion with the community in the East St. Louis Metro Area demonstrated the cumulative impact of SDOH barriers. In their report, Kauth et al. highlighted the importance of trusted sources of health information to help residents understand the complexity associated with their health insurance coverage, when to initiate care and how to ensure continuity of care for key populations, and how to adhere to recommendations from their health providers. Residents highlighted several issues: (1) the need to access educational tools and platforms that could help them lead a healthy lifestyle, especially for healthy eating; (2) concerns about the transportation cost to healthcare services and full-service grocery stores; and (3) the scarcity of community-based healthcare facilities that accept their insurance or provide relation-based patient-centered care, leading some to seek care outside their community or delay care. Furthermore, the community highlighted the impact of living in a resource desert where options for food, green space, transportation, and health facilities are limited while unhealthy food options are readily available.

10. CARE INTEGRATION AND COORDINATION

The project consortium aims to leverage its resources to coordinate care between health providers in different settings, reach out to community members to increase awareness about resources available in the community to address their health needs, and break the transportation barriers by coordinating trips to medical visits and non-medical health-related services.

The care coordinators will generally see clients in healthcare facilities. We recognize that the flow of patients varies. However, to ensure that all patients benefit, care coordinators will need to be on duty for most shifts, even those with a light workload. Based on this, we expect that a full-time care coordinator would see one patient per hour on average. Over a year's work schedule (40 hours per week times 52 weeks per year), there might be 2,080 encounters with the coordinator in a year, at a cost of \$24.04 per encounter. CHWs will see clients in their homes and may work with clients in booking appointments for recommended services. Because of the need for travel and the fact that some clients will not be home at the time of the visit, the productivity will appear lower than for the care coordinator. We expect them to serve half the clients served by care coordinators (1,040) at a cost of \$43.27 per encounter.

The Partnership will not have a direct relationship with MCOs. However, JewelRide has contractual relationships with institutional brokers who have direct relationships with MCOs to provide non-emergency medical transportation to patients. Also, the academic partner will invite the MCOs to participate in the evaluation process by requesting access to claims, encounter, and enrollment data for members in the catchment areas to estimate the change in patient care processes and health outcomes due to the Partnership.

11. MINORITY PARTICIPATION

The Partnership believes in and values the inclusion of minority entities in advancing health equity and health outcomes in the region. The involvement of minority-owned business enterprises (MBEs) brings about concepts of disruption, innovation, paradigm shift, and design thinking in health equity solutions. MBEs can lead or participate in championing and implementing health equity solutions in communities. These businesses can deploy unique skills and access resources to serve a variety of roles in community-based solutions for health equity. These important characteristics are of significant value to driving and contributing to the communities mitigating SDOH, improving access to health, and subsequently improving health outcomes in communities where these businesses are located.

First, minority-owned businesses have an affinity for the residents of distressed communities and are committed to community development. Second, these businesses are becoming increasingly important as generators of jobs for disadvantaged communities. This has resulted from the rapid growth of these businesses in Illinois and their tendency to employ people from disadvantaged communities. Finally, a significant portion of the workforce in minority-owned firms is drawn from low-income neighborhoods in the metro area; indeed, some of the most successful minority-owned businesses are located in low-income neighborhoods. Ignoring the potential contributions of minority-owned businesses in providing social determinant and health access solutions to the East St. Louis Metro Area health equity disparities would be an unfortunate oversight. Across the U.S., evidence shows that minority business entities want to help their neighborhoods and contribute to the improved health equity in these communities.

The Partnership has one active participating organization and several community-based services organizations who will be co-opted into this Transformation project classified as a minority entity.



JewelRide, the lead and active agency on this application, a certified MBE, will lead the Partnership on fiduciary and grants management. JewelRide has been certified through the Illinois Department of Central Management Service's Business Enterprise Program. (See Annex 6, MBE certification.)

JewelRide is 100% minority owned by a pharmacist and a physician who started the company after realizing from first-hand experience how transportation constraints affected access to healthcare for marginalized communities. The co-Founder and CEO of JewelRide (a pharmacist) will lead the Partnership as the collaboration manager while the co-Founder and chief medical advisor will provide a medical advisory role for the Partnership. As health professionals with decades of experience providing direct medical care and managing public health programs of varying complexities, these two key JewelRide members bring not only a passion to transform lives of fellow minorities but also the technical expertise and depth required to transform that passion into reality. JewelRide's special focus will include leading the governance of the Partnership, through the Regional Advisory Board, to ensure that the Partnership is organizationally cohesive and

optimized to fully deliver social determinants and health equity services to the metro area. Also, the enterprise addresses the NEMT aspect of SDOH that negatively impacts the access and delivery of healthcare services. Transportation is seen as a critical stepping stone and cornerstone of improving access to quality health within the region, and synergistically contributes to improving health outcomes taken together with other solutions proposed in this Transformation project.

Minority participation is gathered through the many service agencies that are collaborating on the proposed transformation solutions in the East St. Louis Metro Area. Many of these entities, including some partners in this collaboration, are owned and operated by minorities or provide services to minority members in the region. The sourcing of materials for the Transformation project will focus on using contractors from the Illinois Business Enterprise Program listing of certified minority-owned businesses. Contracting will be focused on firms that employ minorities extensively where it is not possible to directly contract with an MBE.

Below is a list of organizations, local providers, and minority businesses that will play key roles in this Transformation and will link services with CHWs to ensure access to their services in the community. These organizations **owned/operated by minorities** include:

- ***Make Health Happen:*** A community partnership working to promote healthy eating while increasing access to healthy food options in the East St. Louis Metro Area.
- ***Racial Harmony:*** A not-for-profit 501(C) (3) community organization dedicated to making a difference through mediation, teaching, training, and cooperative learning.
- ***The Mount Calvary Church:*** A registered member of the internationally recognized Church of God In Christ, Inc. A Lutheran Church that serves Washington Park and surrounding communities will help support community outreach through CHWs.
- ***Sav-A-Lot:*** One of the few Black grocery store owners in St. Clair County offering healthy fresh food; education; and cooking classes. The store will be partnering with the project to support food access and nutrition classes.
- ***The Grind Fitness and Performance:*** A business with over 10 years of experience training students and adults, specializing in toning, weight loss, nutrition, muscle mass, speed, agility, conditioning, and academics. This entity will become a referral source to assist our patients in accessing a health and fitness center.

In addition to substantial involvement for racial minority businesses in providing services, ***female-owned businesses*** are also extensively involved in this Transformation project, including:

- ***Barbo Design:*** An independent marketing and communications firm that will be used for local community promotions related to the new transformation and services.
- ***YCG Accounting:*** A firm based in Madison County that will provide an accounting and financial management system and manage the payroll of JewelRide.
- ***Moonlight Computing LLC:*** A business providing website design, development, and hosting services in addition to providing technology solutions for small businesses.
- ***BJ's Printables:*** A firm based in Madison County, that manufactures uniforms for service provider staff, e.g., for JewelRide drivers.
- ***Elderly Care Concepts:*** A woman- and minority-owned and community-based organization based in St. Clair County that advocates for seniors to enable the community to help families and seniors navigate the healthcare system and also provide home-based care management services.

- ***Soup-n-Share:*** A woman-owned MBE based in Madison County the believes that everyone deserves access to adequate resources to meet their vital needs. The entity makes sure those in its community can get healthy food through a food bank, and other necessities for themselves and their families while having their dignity affirmed every step of the way.
- ***The Sweet Potato Patch:*** An organization that has been working with SIHF to provide healthy meals, fresh fruits and vegetables, and cooking classes to African American pregnant women. This service has been extended to help individuals with diabetes and hypertension.

JewelRide currently has small business service providers with which it is working and will continue working in the Transformation project. These include:

- ***Main Street Automotive:*** A small business auto shop servicing vehicles based in St. Clair County.
- ***Metropolitan Insurance:*** A minority- owned small business providing insurance for automobility, general liability, and workman's compensation.
- ***Eclipse Car Wash:*** A small business based in Madison County, providing vehicle washing and placed under a contracted service provider agreement.
- ***Minuteman Press:*** A small business based in Madison County, providing cover special printing and copy needs, such as business cards, vehicle decals, and event banners.

12. JOBS

The East St. Louis Metro region presents a picture of a community with few jobs or resources and community members struggling to survive in almost every aspect of their lives. The region is reflective of the African American segment of the overall population and is marked by the following statistics:

- Over 33% of the region lives in poverty.
- A significant percent of the population (76%) meets the federal standard for low income (200% of poverty and below).
- Of those under 18 years of age, 45% of children in the East St. Louis Metro region live in poverty and 84% of families led by single mothers live in poverty.
- The median household income is \$19,520 a year compared with the U.S. average of \$53,482 a year.
- Educational attainment in the region is low, with only 12% of the population having a college degree; fewer than 17% have not finished high school (U.S. Census American Community Survey, 2019).
- Unemployment in St. Clair County as a whole is 7.6% in line with 7.8% throughout Illinois but higher than the national rate of 6.3%.
- In the East St. Louis Metro region, the unemployment rate is dramatically higher at 11.9%, while the U.S. average is 6.0%.
- Although the region has seen an increase in the job market of 2.1% over the last year, future job growth over the next 10 years is predicted to be 27.6%, which is lower than the U.S. average of 33.5%.
- Inclusive to improving some SDOH and health outcomes, creating jobs and opportunity is a focus of this Transformation project.

The Partnership strategy to increase its economic investment in the local neighborhoods includes (1) creating jobs through the anchor institutions and minority business enterprises, e.g., job creation through NEMT improvement in local neighborhood and hiring CHWs and care coordinators who are all residents of the region; (2) purchasing from local and minority groups and following a transparent sourcing policy to increase minority business opportunities; and (3) providing contract opportunities for local small businesses. (See Annex 6 for letters of support in downstream job creation.) The focus on employing local staff will be a pillar of the contractual intent for all collaborating partners. These job creation approaches are couched in the SDOH framework and are highly consistent with the role of multi-sector collaboration. Furthermore, they show the importance of shared values and self-interest as motivating forces for the Partnership to play an active and strategic role in improving living conditions and quality of life in surrounding communities.

Each of our transformational solutions for increased healthcare service and increased community engagement is a critical cornerstone to advancing employment opportunities and addressing some SDOH. Increasing NEMT service and access, coupled with the community health mobilization and provision of services including partnering with the three health systems and research institute, will contribute to creating new healthcare, commercial, and social service jobs throughout the region. The healthcare service delivery approach will contribute to building a more comprehensive healthcare workforce in this region.

Within this region, CHS, HSHS, SIHF, and TRH represent four of the largest employers in Madison and St. Clair Counties, and CHS, HSHS, and TRH are the region's top three employers in the health sector. CHS currently has 675 total employees across all its locations. TRH employs 637, while HSHS has a total of 1,200 employees. In interviews, key informants from these healthcare facilities and hospitals indicated that a significant proportion of their employees were African Americans who were residents of the East St. Louis Metro Area. Furthermore, they indicated that the proportion of African American employees correlates with the percent of patients they serve that are African American. The lead agent in this Partnership, JewelRide, has a total of 16 persons; 50% are African American, 60% are women, and 20% are veterans.

All employees of JewelRide are residents of the East St. Louis Metro Area. For this Transformation project, JewelRide will hire individuals resident within the zip codes of the East St. Louis Metro Area.

The Transformation project intends to deploy CHWs across the region, which will be another pillar of job growth for the community to be used to ultimately employ six new CHWs by the end of year 5. This initiative will help us elevate the economic and social health of our residents. Each transformational area brings forth substantial opportunities for employment and regional job growth. Job creation under this Transformation project will provide the opportunity for individuals who have lived in poverty to migrate to a sustainable career in their trades. TRH, SIHF, and HSHS, including CHS, have already committed through this Transformation project to add on an additional seven staff here in the local community.

The capacity to link our transformation in coordination with the respective commercial services will also produce new opportunities for job growth and sustain the current job status on some commercial services. Downstream minority enterprises like the accounting firms, auto-mechanic shop, uniforms shop, insurance companies, and car-washing places will be subcontracted to continue to provide services to the Transformation project. Also, JewelRide will continue contracting the three institutional brokers providing transportation logistics support on behalf of all Medicaid-supported MCs in the state of Illinois. JewelRide works with these providers as healthcare transportation providers to cover non-emergency medical transportation rides in Madison County and St. Clair County. These are:

- Medical Transportation Management Inc
- Modivcare
- First Transit

In total, this Transformation project will create 50 full-time jobs for the duration of the project and beyond. Overall, the impact of these jobs includes families having stable economic livelihood, which will enable stability in social and health livelihoods of communities of the East St. Louis Metro

Area. Jobs directly created to provide services and complete activities proposed through this Transformation are described below.

For the Transportation Services: JewelRide

Employment will be biased toward hiring veterans, minorities, and women, all resident in the zip codes of East St. Louis Metro Area. This will also apply to the jobs being created across all other partners. Positions include:

- 25 drivers
- 3 dispatch managers/customer care
- 1 collaboration manager
- 1 operations manager
- 1 medical advisor
- 1 human resources manager
- 1 public relations and marketing manager
- 1 fleet manager
- 2 dieticians

For the Community Health Worker: Faith in Action and NAACP

- 6 community health workers

For the Care Coordinator: Hospitals, CHS, and MEPA

- 8 care coordinators

Table 12.1 lists a set of equity and community benefits indicators and metrics that the Partnership will adopt to track its contributions and progress toward goals related to improving community well-being and wealth. A dashboard will be developed that enables partners to use a shared metric for assessing progress.

Table 12.1 Equity and Community Benefits Indicators and Metrics

OUTCOME	INDICATORS	DATA SOURCE
Equitable local and minority hiring	● Percent of local and minority hires in staff position	Institutional data
	● Percent of employed at living wage or above	
Equitable local and minority business procurement	● Percent of procurement dollars directed to local, small business, minority-owned, and women-owned businesses	Institutional data
Thriving business incubation	● Jobs and business created and retained (one year, five years)	Institutional data
	● Dollars directed toward seed funding for minority, women, and small community-owned business	

In addition to at least 50 jobs that will be created, several community-based small businesses will benefit from the downstream increased business opportunities. The lead collaborator in this Partnership currently uses and will continue to use the following organizations under the Partnership project:

- YCG, a woman-owned accounting firm
- Metropolitan Insurance, a minority-owned insurance company
- Main Street Automotive, an auto company offering repair and maintenance work for vehicles
- Eclipse Car Wash, a small business offering car wash services on a regular contracted services basis
- Minuteman Press, a small business providing printing and copy needs, such as business cards, vehicle decals, and event banners

13. EQUITY METRICS

The Partnership's objectives and goals are aligned with the HFS quality strategy to increase preventive care screening. Also, if the proposal were successful, the Partnership activities would have a positive impact on (1) adults' access to preventive/ambulatory health services, measured as the percentage of Medicaid members 20 years or older in the catchment area of St. Clair and Madison Counties who had an ambulatory or preventive care visit during the year measured, (2) persons screened for SDOH, including transportation in the hospital and non-hospital settings, and (3) increase in the use of preventive and ambulatory services by race.

Ideally, these measures would be monitored and evaluated using claims and encounter data. The academic partner will work with MCOs operating in the catchment area to collaborate on evaluating the impact of the Partnership. For example, the academic partner would evaluate the change in the rate of primary care visits for members of the MCOs who reside in the catchment area, using the enrollee's zip code address, identify those who had a visit with a primary care provider or obstetrics and gynecology specialist between January 1 and December 31, and divide this number by the number of enrollees who live in the catchment areas. The academic partner would evaluate the change using statistical techniques, such as difference-in-difference analysis, to measure the change by comparing the utilization of the specified population before and after the Partnership compared to those who don't reside in the Partnership catchment areas.

If access to claims and encounter data is not possible, then the academic partner will work with the provider arm of this Partnership to evaluate the change in the patient mix for preventive and ambulatory services before and during the intervention. Ideally, this will include a racial as well as geographic breakdown. Also, the Partnership will monitor the distribution of rides by the pick-up location. It will link these locations with the census to determine the percentage of minorities. Success will consist of having a large share of pick-ups from predominantly minority communities.

All payments would be handled by an accounting firm. One of the firm's responsibilities would be to implement robust processes for handling collaborating partners' payments and any reimbursements where applicable. The accounting firm we will use is highly experienced in managing funded projects.

The Partnership will work with HFS to determine the appropriate equity metrics and establish a baseline and expected change that the Partnership will be accountable for.

14. QUALITY METRICS

The project consortium quality metrics are aligned with three of the five HFS quality strategy framework priorities that focus on equity, adult behavioral health, community-based services, and support, in addition to improved community placement.

1. Adult behavioral health
 - a. Follow-up after hospitalization for mental health (seven days)
 - b. Follow-up after hospitalization for mental health (30 days)
 - c. Follow-up after ED visit for alcohol and other drug abuse or dependence (seven days)
 - d. Follow-up after ED visit for alcohol and other drug abuse or dependence (30 days)
2. Equity
 - a. Adults' access to preventive/Ambulatory health services
3. Community-based services and support (reported measures)
 - a. Follow-up after high-intensity care for substance use disorder (seven days)
 - b. Follow-up after high-intensity care for substance use disorder (30 days)
 - c. Pharmacotherapy for opioid use disorder
4. Improved community placement
 - a. Follow-up after high-intensity care for substance use disorder (seven days)

SIUE, Department of Applied Health will act as the independent evaluator of this project and will use mixed methods to estimate the impact of this project on patients' health outcomes, well-being, and satisfaction with the services provided, along with the overall cost of care. This will include key informant interviews with stakeholders to understand what worked and the challenges faced during implementation, targeted interviews with patient/community members, interviews to better understand the patient/community member experience, a survey of patients and community members touched by the program, evaluation of the institutions' reports, and if possible, an analysis of Medicaid claims, encounter, and enrollment data to measure the change in quality and outcome measures discussed below.

Under **Goal 1:** Generate demand for follow-up care, SIUE, Department of Applied Health will partner with MCOs in the catchment area in using claims, encounter, and enrollment data to estimate change in quality metrics due to the Partnership, shown in Table 13.1. If access to claims and enrollment data is not possible, then SIUE will collect data from the Partnership providers to estimate change in patients with follow-up visits at non-hospital settings within seven days for mental, ACSCs, and substance use disorders due to the Partnership.

Table 13.1. Partnership Indicators Under Goal 1

Item	Current	Goal
Percent of mental illness hospitalizations in the consortium hospitals with a follow-up visit within seven days	15%	35%
Percent of substance use disorder hospitalizations in the consortium hospitals with a follow-up visit within seven days	29%	50%
Unmet specialty referrals for patients who used the consortium hospitals emergency department	50% (35,561)	10%
Excess emergency department usage due to ACSCs	35% (9,370 of 27,832)	20% of visits

Under **Goal 2:** Generate community-based demand for care in a non-hospital setting for community members with chronic health conditions, mental illness, and substance use disorder

Table 13.2. Partnership indicators under Goal 2: Community-based Demand for Healthcare Indicators and Metrics

OUTCOME	INDICATORS	DATA SOURCE
Community demand to create health equity	<ul style="list-style-type: none"> Number of health educational messages developed by the project consortium 	Institutional data
	<ul style="list-style-type: none"> Number of people reached by the CHWs 	
	<ul style="list-style-type: none"> Number of trips to the full-service grocery store 	Institutional data
	<ul style="list-style-type: none"> Number of people who used the food coach's services 	Institutional data
	<ul style="list-style-type: none"> Member satisfaction and overall health rating 	
	<ul style="list-style-type: none"> Number of people touched who initiated care for their chronic condition, mental illness, and substance use disorder in a non-hospital setting 	Member survey
	<ul style="list-style-type: none"> The number of people who used JewelRide services to address the transportation barrier, 	Member survey and JewelRide data
	<ul style="list-style-type: none"> Percent of people reporting eating nutritious foods within the past two days (e.g., serving of a green vegetable) 	Member survey

Under **Goal 3:** Generate demand for transportation to medical and non-medical health services including full-service grocery stores

Table 13.3. Partnership Indicators Under Goal 3: Demand for NEMT Visits and Healthy Grocery Stores

OUTCOME	INDICATORS	DATA SOURCE
Demand for NEMT	<ul style="list-style-type: none"> Number of people receiving transportation services to health providers 	Institutional data
	<ul style="list-style-type: none"> Rate of services met to booked services 	Institutional data
	<ul style="list-style-type: none"> Clients' satisfaction with the food coach 	Client satisfaction survey
	<ul style="list-style-type: none"> Clients' satisfaction with the transportation services 	Client satisfaction survey
	<ul style="list-style-type: none"> Number of unique individuals who received services from the food coach 	Institutional data

Once metrics are agreed upon in the funding agreement, HFS will establish baseline metrics for the community to track processes under Goals 2 and 3.

15. MILESTONES

Activity	Date
1. Signing funding agreement with HFS	Year 1
2. Establish project infrastructure	
2.a. Training, guidelines, and policies	Year 1
2.b. Information technology infrastructure inducing software and hardware	Year 1
2.c. Data security infrastructure built in compliance with HIPAA policies and regulations	Year 1
2.d. Vehicle purchase	Years 1–4
3. Hire and training care coordinators and CHWs	Year 1
4. Initiating the follow-up demand generation program	Year 1
5. Initiating the CHW community outreach activities	Year 1
6. Initiate the food coach program	Year 2
7. Independent evaluator mid-term report	Year 3
8. Independent evaluator summative report	Year 5

16. SUSTAINABILITY

The proposed transformation efforts would ensure sustainability through the following initiatives:

1. An evidence-based outreach and engagement infrastructure will be established that could be used, with minor modification, to address change in the community, well beyond the project's timeline.
2. The project will create a repository to curate developed policies, guidelines, and training materials and make them available electronically to members of the project consortium. These documents could also be used to share the experience with others through training workshops.
3. Medicaid would pay for transportation to outpatient facilities when authorized. In other cases, providers would pay for transportation, assuming savings from a reduction in missed or broken appointments would cover part of the cost of transportation, and the provider would absorb the balance from its commitment to improving access to care in its most vulnerable patients.
4. To improve access to healthy food, Medicaid might consider covering the cost of transportation based on its projected saving from medical care for adverse events associated with the disease (e.g., obesity, diabetes, and its complications) if nutrition does not change and its commitment to improving the health of its beneficiaries.
5. The capacity to cater to more patients coming through institutional brokers (e.g., MTM, Modivcare, First Transit) will increase. We envision this to be a key driver in relying less and less on transformational funds. Having more rides covered will increase the revenue base. As of November 2021, demand for services from institutional services working on behalf of MCOs far outweighs the capacity of available Medicaid-approved medical transportation providers in the East St. Louis metro area. We see this gap as an opportunity to accommodate more requests from institutional brokers, which will help significantly with transitioning away from transformational funds.
6. With more vehicles and additional personnel (e.g., drivers), capacity to transport more patients and Medicaid members will increase. This will lead to an increased revenue base and a corresponding decrease in reliance on transformational funds with time.
7. JewelRide will work on growing private pay patients who can be accommodated using the same resources (e.g., vehicles) that will be used for other activities proposed in the Transformation project. Private pay customers could be institutional customers such as private hospitals, nursing homes, and rehabilitation centers. Revenue from this stream is expected to increase with each subsequent year in the program.
8. We expect some of the collaborative partners to start paying for services offered after realizing an increase in business through more people accessing transportation for follow-up care.
9. Madison and St. Clair Counties will be paying for some of the services offered to them. Currently, JewelRide is working with Madison County to provide transportation to COVID-19 vaccination sites to people in Madison County. For any direct transportation requests, the two counties will be paying for the services using their budgetary allocation for community health programs. We expect the need for services to rise at both counties as outreach and education programs help people to know about available access options to receive preventive, treatment, and vaccination services at county facilities.

10. Pharmacies belonging to MEPA will eventually pay for prescription delivery services as the program gathers traction with a corresponding increase in its revenue base as more people patronize their pharmacies for prescription filling and immunization services, e.g., flu shots.

(See Annex 7 for letters from two current customers affirming project sustainability.)

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Annex 1. Accounting Firm Confirmation

YCG CPA
2110 Troy Road
Edwardsville, IL 62025

CREATE a better business

Phone: 618-307-9667
susan.young@ycgaccounting.com

November 12, 2021

Illinois Department of Healthcare and Family Services
Healthcare Transformation Collaboratives (HTCs) program
201 South Grand Avenue, East
Springfield, Illinois 62763

Dear Director Eagleson:

Re: HTC Program

Please accept this letter as confirmation that People in Business, Inc dba YCG Accounting has been serving as the accounting firm for Jewelride, LLC since 2019. We provide professional services for their accounting, budget advisory services, monthly financial statements, payroll, year-end financial statements, and tax preparation. We are in full support of their application under the Healthcare Transformation Collaboratives (HTCs) program.

Local companies, such as Jewelride, LLC are essential to the client-base of our company, which serves only locally-owned businesses.

As a small business, ourselves, we project that the growth of this client will assist us in maintaining our employment levels, securing better wages for our employees, and hopefully, adding jobs to our accounting firm.

We also hire several interns through the Southern Illinois University at Edwardsville Internship Program. The HTC program initiative would assist them with hands-on training to develop their professional accounting skills in the governmental and private collaboration funding area.

This program with Jewelride LLC would have many tangential benefits by increasing our potential as a 100% woman-owned small business accounting firm and building a stronger base for small business in our community.

Please feel free to contact me with any questions or for additional information

Sincerely,


Susan M. Young, CPA

Annex 2. Letters of Support From Collaborating Partners



November 17, 2021

Illinois Department of Healthcare and Family Services
201 South Grand Avenue, East
Springfield, Illinois 62763

Dear Director Eagleson:

Re: Support letter for HTC Program-JewelRide

This letter serves as confirmation of our support and commitment to collaborate with JewelRide, a locally based minority owned medical transportation business, in their application proposal to access transformational funds that if awarded will go towards expanding their scope of work across several geographies in the East St Louis metro area and surrounding communities. Their social mission to improve access to healthcare and wellbeing through provision of HIPPA compliant medical transportation, dovetails well with our work as a multi-faceted behavioral health and human services hospital group operating in the states of Illinois and Missouri serving vulnerable, at risk and underserved populations who sometimes face healthcare transportation constraints. JewelRide are already providing this need to some of our facilities in Madison County-IL and St Clair County-IL but currently are limited in their capacity to fully meet the entire spectrum of some of the pertinent requirements such as long-distance discharge rides and special behavioral health patients' rides. With their increased capacity, we will work with JewelRide closely to close this gap and provide opportunity for uninterrupted continuity of care to all people and in the process addressing health inequity and disparities in the community. We envision working more with JewelRide for healthcare transportation needs for facilities in Granite City, Belleville, Granite City and Maryville. Our continued efforts to address health inequity and disparities significantly depend on eliminating social determinants of health, transportation being one of them. Ultimately, we see JewelRide as an important multisectoral member in our holistic approach to improve health outcomes in all communities we serve.

One again we reiterate our support for JewelRide to be considered for these transformational funds. Their expanded services will likely help with complementing our critical role as a provider of behavioral and mental health services.

Please feel free to contact me with any questions or for additional questions.

Sincerely,

Orville Mercer

50 Northgate Industrial Drive
Granite City, Illinois 62040-6852

Phone: (618) 877-4420 TTY: (618) 877-9920
Fax: (618) 877-9250 (Client Records)



HSHS St. Joseph's Hospital
Breese

HSHS St. Mary's Hospital
Decatur

HSHS St. Anthony's Memorial Hospital
Effingham

HSHS Holy Family Hospital
Greenville

HSHS St. Joseph's Hospital
Highland

HSHS St. Francis Hospital
Litchfield

HSHS St. Elizabeth's Hospital
O'Fallon

HSHS Good Shepherd Hospital
Shelbyville

HSHS St. John's Hospital
Springfield

St. John's College of Nursing
Springfield

November 15, 2021

Theresa Eagleson, Director
Illinois Department of Healthcare and Family Services
Re: Healthcare Transformation Collaboratives (HTC) – Second Round
201 S Grand Ave E
Springfield, IL 62704

Re: Letter of support for Healthcare Transformation Collaboratives (HTC) application

Dear Director Eagleson,

I am writing to enthusiastically support the HTC grant request submitted to you by Tapiwa Mupereki, RPh, MS, Co-Founder and CEO of JewelRide (<https://www.jewelride.com/>). JewelRide is a healthcare transportation company based in Edwardsville, Illinois, that provides non-emergency medical transportation with primary operations in with primary operations in Madison and St. Clair Counties. The primary population served is Medicaid patients (for both ambulatory and wheelchair bound persons). Our hospital social workers and discharge planners frequently struggle to find appropriate transportation for patients with limited mobility, and limited financial means, and often contact Jewelride for patient transportation.

JewelRide has been a valued community partner: Our hospitals in the JewelRide service area are pleased to support this grant application, and will collaborate by continuing to make referrals and recommendations for this provider to provide patient transportation needs. In addition to our HSHS Medical Group and Prairie Cardiovascular Clinics, our hospitals in the JewelRide service area include:

- HSHS St. Elizabeth's Hospital (O'Fallon)
- HSHS St. Joseph's Hospital (Highland)
- HSHS St. Joseph's Hospital (Breese)

Because of limited resources (staffing and vehicles), and sometimes overwhelming demand, JewelRide is sometimes limited in its ability to respond transportation requests from area hospitals.

JewelRide is part of the critical ecosystem providing healthcare transportation to current and future patients seeking medical care at our hospitals and area clinics. JewelRide is a company that helps address Illinois health disparities, particularly in underserved rural areas and the East St Louis metro area in Illinois. Increased JewelRide capacity, through HTC funds, would help patients in the region with needed travel to clinic and hospital appointments. Thank you for the opportunity to support this Round 2 HTC grant application.

Sincerely,

Kimberly Luz, M.S., C.H.E.S.
Division Director of Community Outreach
HSHS Illinois Division

MAILING ADDRESS: 800 E. CARPENTER ST., SPRINGFIELD, IL 62769 | PHYSICAL ADDRESS: 850 E. MADISON ST., SUITE 300, SPRINGFIELD, IL 62702
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**Madison County Government
Health Department**

Toni M. Corona · Director Public Health
101 East Edwardsville Road · Wood River, IL 62095-1332
Phone: (618) 692-8954 · Faxes: Admin (618) 296-7011
Health Protection (618) 692-8905 · Nursing (618) 251-9482

November 16, 2021

Illinois Department of Healthcare and Family Services
201 South Grand Avenue, East
Springfield, Illinois 62763

Dear Director Eagleson:

Re: HTC Program

This note serves as confirmation of our support and commitment to collaborate with JewelRide, a locally based medical transportation small business, in their application proposal to access transformational funds that if awarded will go towards expanding their scope of work across several geographies in Madison County and surrounding communities. Their social mission to improve access to healthcare and wellbeing through provision of HIPPA compliant medical transportation, dovetails well with a need we have to fulfill some of our community health activities. We envision a scenario where their expanded scope will help with catering for healthcare transportation needs for some people visiting County facilities for preventive and treatment care and in the process helping with more enhanced continuity of care which potentially could be severely affected for persons facing transportation constraints. Our continued efforts to address health inequity and disparities significantly depend on eliminating social determinants of health, transportation being one of them. In the recent past, JewelRide have demonstrated the ability to close this gap through a grant funded program where they provide transportation to COVID-19 vaccination sites in any part of Madison County. We see continued increase in capacity utilization as additional younger age groups and certain population groups become eligible for COVID-19 vaccines. Other immunization efforts could also benefit from JewelRide's community focused operations. Ultimately, we see JewelRide as an important multisectoral member in our holistic approach to improve health outcomes.

One again we reiterate our support for JewelRide to be considered for these transformational funds. Their expanded services will likely help with complementing Madison County Health Department's multiple healthcare access programs and initiatives. Please feel free to contact me with any questions or for additional questions.

Sincerely,

A handwritten signature in blue ink that reads "Toni M. Corona".

Toni M. Corona, B.S., L.E.H.P.
Director Public Health



Edwardsville Branch NAACP

Walter D. Williams
President

Traci S. Daniels
1st Vice President

Donnie Howard
2nd Vice President

Charmian Aaron
3rd Vice President

Debra Pitts
Secretary

Fannie Beasley
Asst. Secretary

Ella Hudlin
Treasurer

Tina Wilson
Asst. Treasurer

November 17, 2021

Illinois Department of Healthcare and Family Services
201 South Grand Avenue, East
Springfield, Illinois 62763

Dear Director, Eagleson:

Re: NAACP support letter for JewelRide

This letter serves as a confirmation of our support and commitment to collaborate with JewelRide, a locally based minority-owned medical transportation business, in their application proposal to access transformational funds that if awarded will go towards expanding their scope of work across several geographies in Madison County and surrounding communities. Their goal to address social needs through transportation at the level of the community is one that we fully support and will be able to help expand if they are granted these funds. We will work with them in their community engagement activities and help with being a trusted link in diverse communities including Black communities, Hispanic communities, Asian communities as well as Caucasian communities to improve equitable access to their services. We will also find viable ways to integrate JewelRide in our work to disrupt inequality, dismantle racism and accelerate change in key areas including criminal justice, healthcare, education, climate change and the economy. Ultimately, we will be their social justice partner with a focus on helping their racial equity and minority participation efforts in different areas within Madison County and St Clair County. These two counties have some of the most historically disproportionately affected areas in access to healthcare and social services. We see JewelRide as having a strategic role in alleviating some of these inequities and disparities.

Once again, we reiterate our support for JewelRide to be considered for these transformational funds. We see mutual benefits in collaborating with them in this work.

Please feel free to contact me with any questions or for additional questions.

Sincerely,

A handwritten signature in black ink that reads "Walt Willaims". The signature is written in a cursive style with a large initial "W".

Walt Willaims

NAACP Edwardsville-President



ST. CLAIR COUNTY HEALTH DEPARTMENT

19 PUBLIC SQUARE, SUITE 150
BELLEVILLE, ILLINOIS 62220-1624
<https://www.co.st-clair.il.us>



Cindy Thompson, RN, BSN
President

Myla Blandford, MPH, REHS, LEHP
Executive Director

November 18, 2021

Illinois Department of Healthcare and Family Services
201 South Grand Avenue, East
Springfield, Illinois 62763

Re: HTC Program

Dear Director Eagleson:

This letter serves as confirmation of our support and commitment to collaborate with JewelRide, a locally-based medical transportation small business, in their application to access transformational funds. Should these funds be awarded, they will go toward expanding their scope of work across several geographic areas in St Clair County and surrounding communities. Their social mission, to improve access to healthcare and wellbeing through provision of HIPAA compliant medical transportation, dovetails well with a need we that we have to fulfill some of our community health activities. We envision a scenario where their expanded scope of service will help with catering to the healthcare transportation needs for clientele visiting County facilities for preventive treatment/ care. Increased access to transportation helps enhance continuity of care, which could be negatively impacted for persons facing transportation constraints. Our programs include, but are not limited to: Women, Infants and Children's Supplemental program-WIC, high risk prenatal programs, high risk infant programs and childhood immunizations. Residents' access to these programs will benefit from a partnership with JewelRide. Our continued efforts to address health inequity and disparities significantly depend on eliminating social determinants of health, transportation/access to care being one of them. Ultimately, we see JewelRide as an important stakeholder in our holistic approach to improve health outcomes in the community.

One again, we reiterate our support for JewelRide to be considered for these transformational funds. Their expanded services will likely help with promoting St Clair County Health Department's numerous healthcare programs and initiatives.

Please feel free to contact me with any questions or for additional questions.

Sincerely,

Myla Blandford

Myla Blandford

Myla Blandford, MPH, REHS, LEHP

Executive Director

(618) 825-4413 | myla.blandford@co.st-clair.il.us
St. Clair County Government | Health Department
19 Public Square Suite 150 | Belleville, IL 62220

Administrative/Fiscal
618.233.7703
618.222.1630 fax

Infectious Disease Prevention

- **Communicable Disease**
618.233.6175
618.233.9356 fax
- **Southwestern Illinois HIV Care Connect**
618.825.4501
618.825.4585 fax
- **Emergency Preparedness**
618.233.7703
618.233.9356 fax

Personal Health

- **Maternal-Child Health Programs**
618.233.6170
618.236.0821 fax
- **Breast and Cervical Cancer**
618.233.7703
618.233.7713 fax

Environmental Health

- 618.233.7769
- 618.236.0676 fax

Like and Follow us on:
Facebook: @SCC.HealthDepartment
Twitter: @stclairhealth



Public Health

Prevent. Promote. Protect.

St. Clair County Health Department
together for your health



November 16, 2021

Illinois Department of Healthcare and Family Services
201 South Grand Avenue, East
Springfield, Illinois 62763

Dear Director Eagleson:

Re: Support letter for HTC Program-JewelRide

Please accept this letter as confirmation for our support and commitment to collaborate with JewelRide, a locally based minority owned medical transportation business, in their application proposal to access transformational funds. If awarded the funds will go towards expanding JewelRide's scope of work across several geographies in the East St Louis metro area and surrounding communities.

JewelRide's social mission to improve access to healthcare through provision of HIPPA compliant medical transportation, dovetails well with our work as a safety net hospital. JewelRide currently provides this need to our facilities. However, they are limited in their capacity to fully meet the entire spectrum of some of the pertinent requirements such as long-distance discharge rides and special behavioral health patients' rides.

With their increased capacity, we will work closely with JewelRide to close the gap and provide an opportunity for uninterrupted continuity of care to all people. We will work with JewelRide through Touchette Regional Hospital, SIHF Healthcare and Archview Medical Specialists. Our continued efforts to address health inequity and disparities significantly depend on eliminating social determinants of health, transportation being one of them. Ultimately, we see JewelRide as an important multisectoral asset in our holistic approach to improve health outcomes in the communities we serve.

Once again, we would like to express our support for JewelRide to be considered for transformational funds. Their expanded services will likely help with complementing our critical healthcare safety net role.

Please feel free to contact me with any questions or for additional questions.

Sincerely,

Jay Willsher

A handwritten signature in blue ink, appearing to read "Jay Willsher", is written over the printed name.

5900 Bond Avenue | Centreville, IL 62207 | P: 618.332.3060 | F: 618.332.5256 | touchette.org

Annex 3. Letters of Support for JewelRide in Growing Demand



November 17, 2021

To whom it may concern,

This letter is to serve as verification that JewelRide is a provider in good standing within the MTM Network. In 2021 they have provided several thousand rides for us while maintaining acceptable quality performance. We look forward to working with them in the future and growing their company with MTM. If you have any questions, please feel free to e-mail me directly at thopfensperger@mtm-inc.net.

Best Regards,

Tim Hopfensperger

Director, Logistics Operations



November 16, 2021

Healthcare Transformation Collaboratives

To Whom it may concern:

Modivcare Solutions LLC is currently working with Jewelride LLC, a minority owner business enterprise in the Madison & St. Claire counties in IL and is contracted with them to perform Ambulatory & Wheel Chair trips for member who need transportation for non-emergency medical appointments within that IL region.

We have successfully contracted with JewelRide LLC to perform trips and are hoping to expand trip volume. JewelRide consistently performs on time and quality care for Medicaid and Medicare members with the amount of vehicles they currently have in their fleet. It is our hope that Jewelride can expand their fleet through the necessary funds needed with this program to continue to provide consistently, high quality transportation for the member base they serve in their county locale. It is our hope that they will also be allowed to expand their coverage area to service additional counties once they can obtain additional funds.

Taking into consideration changes in funding or program operation, Modivcare expects to continue to partner and grow with their current operation. We currently offer 1600 trips monthly with Jewelride LLC and would anticipate doubling that volume. Jewelride currently does not have the capacity to handle additional trip volume, and it is our hope that with the Healthcare Transformation Collaborative they will be able to significantly increase ridership and revenue through this association. We understand that this statement in no way binds Modivcare Solutions LLC to any future contractual obligations.

Please consider this letter as our endorsement of JewelRide LLC with this program, as we endorse their community support as well as their minority owned small business certification. Should you need a verbal recommendation of this company, please feel free to call me direct at 708-446-5514.

Sincerely,

Daniel Meneou

Regional Manager

Modivcare Solutions, LLC

RESPECT • TRUST • RELIABLE • COMPASSION • SAFETY • TRANSPARENCY

Annex 4. Letter of Support From NAACP



Edwardsville Branch NAACP

Walter D. Williams
President

Traci S. Daniels
1st Vice President

Donnie Howard
2nd Vice President

Charmian Aaron
3rd Vice President

Debra Pitts
Secretary

Fannie Beasley
Asst. Secretary

Ella Hudlin
Treasurer

Tina Wilson
Asst. Treasurer

November 17, 2021

Illinois Department of Healthcare and Family Services
201 South Grand Avenue, East
Springfield, Illinois 62763

Dear Director, Eagleson:

Re: NAACP support letter for JewelRide

This letter serves as a confirmation of our support and commitment to collaborate with JewelRide, a locally based minority-owned medical transportation business, in their application proposal to access transformational funds that if awarded will go towards expanding their scope of work across several geographies in Madison County and surrounding communities. Their goal to address social needs through transportation at the level of the community is one that we fully support and will be able to help expand if they are granted these funds. We will work with them in their community engagement activities and help with being a trusted link in diverse communities including Black communities, Hispanic communities, Asian communities as well as Caucasian communities to improve equitable access to their services. We will also find viable ways to integrate JewelRide in our work to disrupt inequality, dismantle racism and accelerate change in key areas including criminal justice, healthcare, education, climate change and the economy. Ultimately, we will be their social justice partner with a focus on helping their racial equity and minority participation efforts in different areas within Madison County and St Clair County. These two counties have some of the most historically disproportionately affected areas in access to healthcare and social services. We see JewelRide as having a strategic role in alleviating some of these inequities and disparities.

Once again, we reiterate our support for JewelRide to be considered for these transformational funds. We see mutual benefits in collaborating with them in this work.

Please feel free to contact me with any questions or for additional questions.

Sincerely,

P. O. Box 12 • Edwardsville, IL 62025 • (618) 363-5738 edwardsvillenaacp@gmail.com <http://edwardsvillenaacp.org/>



Walt Williams

NAACP Edwardsville-President

Annex 5. MBE Certification



ILLINOIS

JB Pritzker, Governor

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

Janel L. Forde, Director

May 27, 2021

Mr. Tapiwa Mupereki
JewelRide LLC
22 Loggers Trail
Edwardsville, IL 62025

Dear Tapiwa Mupereki:

Re: Minority Business Enterprise (MBE)
Certification Term Expires: May 27, 2022

Congratulations! After reviewing the information that you supplied, we are pleased to inform you that your firm has been granted certification under the Business Enterprise Program (BEP) for Minority, Females, and Persons with Disabilities.

This certification is in effect with the State of Illinois until the date specified above.

At least 15 days prior to the anniversary date of your certification, you will be notified by BEP through email to update your certification as a condition of continued certification. It is your responsibility to ensure that the contact email address listed in the system is accurate and up to date and that the email account is checked regularly so that you do not miss any important notifications. In addition, should any changes occur in ownership and/or control of the business or other changes affecting the firm's operations, you are required to notify BEP within two weeks. Failure to notify our office of changes will result in decertification of your firm.

Your firm's name will appear in the State's Directory as a certified vendor with the Business Enterprise Program in the specialty area(s) of:

NIGP 95294: TRANSPORTATION SERVICES: ELDERLY, HANDICAPPED, INCAPACITATED, PRISONERS, JURIES, STUDENTS.
ETC.

Your firm will only show up in the database of BEP-certified vendors under the NIGP codes listed above, so PLEASE REVIEW THE LIST CAREFULLY TO ENSURE THAT ALL RELEVANT NIGP CODES ARE INCLUDED.

Also, please be advised that this certification does not guarantee that you will receive a State contract. Please visit the Vendor Registration page on www.opportunities.illinois.gov and be sure to register with each of the Procurement Bulletins listed so that you are notified of upcoming solicitations in your NIGP codes. Certification with the Business Enterprise Program does not ensure you receive notifications; you must also register with Procurement Bulletins.

Thank you for your participation in the Business Enterprise Program. We welcome your participation and wish you continued success.

Sincerely,

Carlos Gutiérrez
Certification Manager
Business Enterprise Program

Annex 6. Letters of Support for *Downstream* Job Creation



November 15, 2021

Illinois Department of Healthcare and Family Services
Healthcare Transformation Collaboratives (HTCs) program
201 South Grand Avenue, East
Springfield, Illinois 62763

Dear Director Eagleson:

We are writing to confirm that we work with JewelRide LLC as a service provider. We cater for all their employee uniform needs for the different seasons of the year. They are a valuable regular customer. We are in full support of their application under the Healthcare Transformation Collaboratives (HTCs) program. Their growth would be a welcome move to the downstream benefits they create to us as a woman owned small business in the community.

Do not hesitate to reach us for any questions.

Sincerely,

A handwritten signature in blue ink that reads 'J Manley'.

Julie Manley
BJ's Printables, Inc.
1501 Troy Road Suite B
Edwardsville, IL 62025
618.656.8625
julie@bjsprintables.com

November 12, 2021

Illinois Department of Healthcare and Family Services
Healthcare Transformation Collaboratives (HTCs) program
201 South Grand Avenue, East
Springfield, Illinois 62763

Dear Director Eagleson:

We are writing to confirm that we work with JewelRide LLC as a service provider. We cater for all their printing and vehicle decals needs. They are a valuable and consistent regular customer. We are in full support of their application under the Healthcare Transformation Collaboratives (HTCs) program. Their growth would be a welcome move to the downstream benefits they create to us as a small business in the community.

Do not hesitate to reach us for any questions.

Sincerely,


Michelle

Main Street Automotive LLC

2004 W. Main St.
Belleville, IL 62226

Phone: 618-416-7654



NOV 12 2021

November 12, 2021

Illinois Department of Healthcare and Family Services
Healthcare Transformation Collaboratives (HTCs) program
201 South Grand Avenue, East
Springfield, Illinois 62763

Dear Director Eagleson:

We are writing to confirm that we work with JewelRide LLC as a service provider. We cater for all their auto mechanic maintenance and repair needs for the vehicles they use for their medical transportation business. We are in full support of their application under the Healthcare Transformation Collaboratives (HTCs) program. Their growth would be a welcome move to the downstream benefits they create to us as a small business in the community. If they get more vehicles, we will also have increased work we will be doing for them.

Do not hesitate to reach us for any questions.

Sincerely, DANNY BRIDGES

Metropolitan Ins Serv Cons Inc
Jory Gruenberg
5550 N. Elston Ave
Chicago, IL 60630
Phone: 888-822-6519 Fax: 773-631-6641

Illinois Deptmt of Healthcare
Family Svcs (HTCs) program
201 South Grand Avenue, East
Springfield, IL 62763

M E M O			Page 1
TO:	BY:	DATE:	
JEWELRI	CK	11/15/2021	
POLICY INFORMATION			
POLICY #			
BRPCLLTIL011100-080203-01			
TYPE		EFFECTIVE	EXPIRATION
PTPL		11/01/2021	11/01/2022

Director Eagleson

Re: Support Letter

Dear Director Eagleson:

We are writing to confirm that we work with JewelRide LLC as a service provider. We cater for all their insurance needs including auto liability, general liability, and workman's compensation. We further confirm that they currently have 17 special medical transportation vehicles that are commercially insured with us. We are in full support of their application under the Healthcare Transformation Collaboratives (HTCs) program. Their growth would be a welcome move to the downstream benefits they create to us as a minority owned small business in the community.

Do not hesitate to reach us for any questions.

Jory Gruenberg



YCG CPA

2110 Troy Road
Edwardsville, IL 62025

CREATE a better business

Phone: 618-307-9667

susan.young@ycgaccounting.com

November 12, 2021

Illinois Department of Healthcare and Family Services
Healthcare Transformation Collaboratives (HTCs) program
201 South Grand Avenue, East
Springfield, Illinois 62763

Dear Director Eagleson:

Re: HTC Program

Please accept this letter as confirmation that People in Business, Inc dba YCG Accounting has been serving as the accounting firm for Jewelride, LLC since 2019. We provide professional services for their accounting, budget advisory services, monthly financial statements, payroll, year-end financial statements, and tax preparation. We are in full support of their application under the Healthcare Transformation Collaboratives (HTCs) program.

Local companies, such as Jewelride, LLC are essential to the client-base of our company, which serves only locally-owned businesses.

As a small business, ourselves, we project that the growth of this client will assist us in maintaining our employment levels, securing better wages for our employees, and hopefully, adding jobs to our accounting firm.

We also hire several interns through the Southern Illinois University at Edwardsville Internship Program. The HTC program initiative would assist them with hands-on training to develop their professional accounting skills in the governmental and private collaboration funding area.

This program with Jewelride LLC would have many tangential benefits by increasing our potential as a 100% woman-owned small business accounting firm and building a stronger base for small business in our community.

Please feel free to contact me with any questions or for additional information

Sincerely,


Susan M. Young, CPA

Annex 7. Letters From Two Current Customers Affirming Project Sustainability



November 17, 2021

To whom it may concern,

This letter is to serve as verification that JewelRide is a provider in good standing within the MTM Network. In 2021 they have provided several thousand rides for us while maintaining acceptable quality performance. We look forward to working with them in the future and growing their company with MTM. If you have any questions, please feel free to e-mail me directly at thopfensperger@mtm-inc.net.

Best Regards,

Tim Hopfensperger

Director, Logistics Operations



November 16, 2021

Healthcare Transformation Collaboratives

To Whom it may concern:

Modivcare Solutions LLC is currently working with Jewelride LLC, a minority owner business enterprise in the Madison & St. Claire counties in IL and is contracted with them to perform Ambulatory & Wheel Chair trips for member who need transportation for non-emergency medical appointments within that IL region.

We have successfully contracted with JewelRide LLC to perform trips and are hoping to expand trip volume. JewelRide consistently performs on time and quality care for Medicaid and Medicare members with the amount of vehicles they currently have in their fleet. It is our hope that Jewelride can expand their fleet through the necessary funds needed with this program to continue to provide consistently, high quality transportation for the member base they serve in their county locale. It is our hope that they will also be allowed to expand their coverage area to service additional counties once they can obtain additional funds.

Taking into consideration changes in funding or program operation, Modivcare expects to continue to partner and grow with their current operation. We currently offer 1600 trips monthly with Jewelride LLC and would anticipate doubling that volume. Jewelride currently does not have the capacity to handle additional trip volume, and it is our hope that with the Healthcare Transformation Collaborative they will be able to significantly increase ridership and revenue through this association. We understand that this statement in no way binds Modivcare Solutions LLC to any future contractual obligations.

Please consider this letter as our endorsement of JewelRide LLC with this program, as we endorse their community support as well as their minority owned small business certification. Should you need a verbal recommendation of this company, please feel free to call me direct at 708-446-5514.

Sincerely,

Daniel Meneou

Regional Manager

Modivcare Solutions, LLC

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Annex 8. Vehicle Quote



Quote

Proposal #:Q217100

WMK LLC
155 E. North Avenue
Villa Park, IL 60181
(630) 782-1900
EIN#: 31-1502439
fax: (630) 782-1950

Price Quote Valid for 14 Days

Drew Chuipek Email: drew.chuipek@mobilityworks.com Phone: (847) 363-9059

Billing Name JewelRide LLC	Buyer Name JewelRide LLC	Stock #
Address 2110 Troy Road, Suite G	Address 2110 Troy Road, Suite G	Quote # Q217100
City, State ZIP Edwardsville, IL 62025	City, State ZIP Edwardsville, IL 62025	Proposal Date 10/26/2021
County Madison	County Madison	Accepted date
Telephone (618) 250-4771	Telephone (618) 250-4771	

<i>New/Used</i>	<i>Make</i> Ford	<i>Model / Trim</i> T350	<i>Year</i> 2022	<i>Color</i> White	<i>To Be Delivered On Or About</i> 04/29/2022											
<i>Type of Vehicle</i>	<i>VIN</i> TBD	<i>Mileage</i> 10	<i>Job Reference:</i> <i>Customer P.O.:</i>													
Chassis, Conversion and Additional Equipment (See Page 2 for detail):					\$67,254.00											
Protection Products:					\$0.00											
<p>*Quote is for (30) 2022 Transit 350's Medium Roofs totaling 7 ambulatory passengers (5 in the rear) plus 2 wheelchair positions</p> <p>*30 units x \$67,204 a piece = \$2,016,120 not including tax</p> <p>*Rebates are subject to change from Ford at time of delivery</p> <p>*Delivery time frame is February-May</p>					<i>MBW Rewards</i>	(\$0.00)										
					Total	\$67,254.00										
					<i>Documentary Fee</i>	\$0.00										
					<i>License Fee</i>	\$200.00										
					<i>Delivery</i>	\$750.00										
					<i>Sales tax</i>	\$0.00										
					Total Cash Delivered Price	\$68,204.00										
					<i>Note 1 Rebate(s)</i>	(\$1,000.00)										
					<i>GPC</i>	(\$0.00)										
					<i>Third Party Payor(s)</i>	(\$0.00)										
<table border="1"> <tr> <td><i>Cash Down</i></td> <td><i>Check/PO</i></td> <td>-</td> <td>-</td> </tr> <tr> <td><i>Payment</i></td> <td><i>Deposit Amount + Cash Down Payment</i></td> <td>(\$0.00)</td> <td></td> </tr> <tr> <td colspan="3">Total Credits</td> <td>(\$1,000.00)</td> </tr> </table>					<i>Cash Down</i>	<i>Check/PO</i>	-	-	<i>Payment</i>	<i>Deposit Amount + Cash Down Payment</i>	(\$0.00)		Total Credits			(\$1,000.00)
<i>Cash Down</i>	<i>Check/PO</i>	-	-													
<i>Payment</i>	<i>Deposit Amount + Cash Down Payment</i>	(\$0.00)														
Total Credits			(\$1,000.00)													
Trade-In(s)																
<i>Year</i>	<i>Make</i>	<i>Model</i>	<i>Vin</i>	<i>Payoff Amount</i>	<i>Allowance</i>											
<p>ONLY THOSE ITEMS AND SERVICES SPECIFICALLY WRITTEN ON THIS ORDER ARE INCLUDED IN THE STATED PRICE. ANY OTHER AGREEMENTS, UNLESS IN WRITING, ARE NOT BINDING ON SELLER.</p>					Amount Due Upon Delivery	\$67,204.00										

The first and second pages of this Order comprise the entire agreement affecting this purchase and no other agreement or understanding of any nature concerning this purchase has been made or entered into, or will be recognized. I hereby certify that no credit has been extended to me for the purchase of this motor vehicle except as appears in writing on the face of this agreement.

I have read and understand the second page of this agreement and agree to it as a part of this order the same as if it were printed above my signature. I certify that I am of legal age, or older, that I have legal capacity and authority to execute this agreement on behalf of my company, and hereby acknowledge receipt of a copy of this order.

Buyer's Signature **JewelRide LLC**

Approved By: **Drew Chuipek**

Co-Buyer's Signature

This order is not valid unless signed and accepted by dealer and is only valid for 14 days.

Note 1 OEM Incentives and availability are subject to change and the end user must meet qualifications by OEM to qualify.

